Commonwealth of Kentucky
KY Medicaid

Provider Billing Instructions For Nursing Facility and Intermediate care Facility/ Mental Retardation/ Developmentally Disabled Services Provider Type – 11, 12

Version 4.8

September 4, 2012

Document Change Log

Document Version	Date	Name	Comments
1.0	10/14/2005	HP Enterprise Services	Initial creation of DRAFT Home Health Services Provider Type – 34.
1.2	01/19/2006	HP Enterprise Services	Updated Provider Rep list.
1.3	02/16/2006	Carolyn Stearman	Updated with revisions requested by Commonwealth.
1.4	03/28/2006	Lize Deane	Updated with revisions requested by Commonwealth.
1.5	04/27/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.5	05/24/2006	Cathy Hill	Adjusted margins as needed.
1.6	05/30/2006	Tammy Delk	Updated with revisions requested by Commonwealth.
1.7	09/18/2006	Ann Murray	Replaced Provider Representative table.
1.7	10/30/2006	Ron Chandler	Insert new UB-04 form and descriptors.
1.7	10/31/2006	Cathy Hill	Insert revisions requested by internal reviewers.
1.8	11/14/2006	Lize Deane	Revisions made according to comment log.
1.9	11/15/2006	Lize Deane	Insert UB-04 with NPI.
2.0	01/30/2007	Ann Murray	Updated with revisions requested by Stayce Towles.
2.1	01/30/2007	Ann Murray	Updated with revisions requested during walkthrough.
2.2	02/15/2007	Ann Murray	Updated Appendix D, KY Medicaid card and ICN.
2.3	02/21/2007	Ann Murray	Replaced Provider Rep table.
2.4	02/23/2007	Ann Murray	Revised according to comment log Walkthrough.
2.5	05/03/2007	Ann Murray	Updated and added claim forms and descriptors.

2.6	05/15/2007	Cathy Hill	Inserted text in UB04 Field Descriptions as specified by the TFAL v2.5 – 2.6 are actually the same as revisions were made back-to-back and no publication would have been made
2.7	05/19/2008	Cathy Hill	Inserted revised provider rep list and presumptive eligibility per Stayce Towles.
2.8	05/20/2008	Cathy Hill	Made revisions requested by Stayce Towles. v2.7 – 2.8 are actually the same as revisions were made back-to-back and no publication would have been made
2.9	06/12/2088	Ann Murray	Updated section 4.6 Prior Authorization Information.
3.0	07/23/2008	Ann Murray	Updated with changes for Medicare.
3.1	03/09/2009	Cathy Hill	Made changes from KyHealth Choices to KY Medicaid per Stayce Towles
3.2	03/11/2009	Cathy Hill	Revised contact info from First Health to Dept for Medicaid Services per Stayce Towles
3.3	03/30/2009	Ann Murray	Made global revisions per DMS request. v3.1 – 3.3 are actually the same as revisions were made back-to-back and no publication would have been made
3.4	09/08/2009	Ann Murray	Replaced Provider Rep list.
3.5	10/21/2009	Ron Chandler	Replaced all instances of “EDS” with “HP Enterprise Services”.
3.6	11/10/2009	Ann Murray	Replaced all instances of @eds.com with @hp.com. Removed HIPAA section. v3.5 – 3.6 are actually the same as revisions were made back-to-back and no publication would have been made
3.7	03/08/2010	Ron Chandler	Inserted new provider rep list.
3.8	06/23/2010	Ann Murray	Updated Detailed Billing instructions and Appendix A
3.9	6/28/2010	Ron Chandler	Revised pages 35 and 43, field 4. v3.8 – 3.9 are actually the same as revisions were made back-to-back and no publication would have been made

4.0	11/18/2010	Patti George Ron Chandler	Revised per Patti George paper document with markup.
4.1	01/18/2011	Ann Murray	Updated global sections. v4.0 – 4.1 are actually the same as revisions were made back-to-back and no publication would have been made
4.2	05/04/2011	Patti George	Replace occurrences of SHPS with Carewise Health, Inc.
4.3	11/29/2011	Brenda Orberson Ann Murray	Updated 5010 changes. DMS approved 12/27/2011, Renee Thomas
4.4	02/08/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 02/14/2012, John Hoffman
4.5	02/22/2012	Brenda Orberson Ann Murray	Global updates made to remove all references to KenPAC and Lockin. DMS Approved 03/09/2012, John Hoffman
4.6	04/05/2012	Stayce Towles Ann Murray	Updated provider rep listing. DMS Approved 04/11/2012, John Hoffman
4.7	06/04/2012	Stayce Towles Ann Murray	Updated sections 7.3.1 and 7.5.1 and added section 7.6 Duplicate or Inappropriate Payments based upon HP recommendation with DMS approval from Alisha Clark. DMS Approved 06/04/2012, Betty Murphy
4.8	08/30/2012	Stayce Towles Patti George	Replace Provider Inquiry form with new form approved by John Hoffman on 08/30/2012

TABLE OF CONTENTS

1 General

1.1 Introduction

These instructions are intended to assist persons filing claims for services provided to Kentucky Medicaid Members. Guidelines outlined pertain to the correct filing of claims and do not constitute a declaration of coverage or guarantee of payment.

Policy questions should be directed to the Department for Medicaid Services (DMS). Policies and regulations are outlined on the DMS website at:

http://chfs.ky.gov/dms/Regs.htm

Fee and rate schedules are available on the DMS website at:

http://chfs.ky.gov/dms/fee.htm

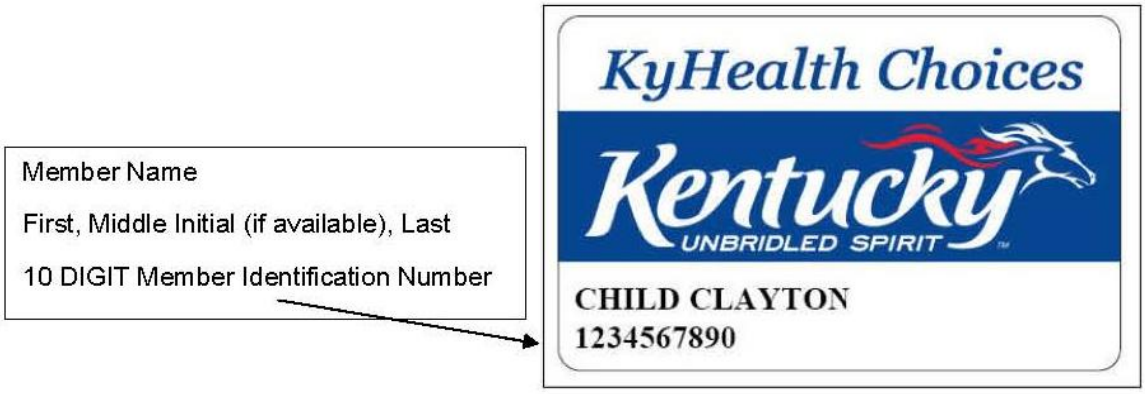
1.2 Member Eligibility

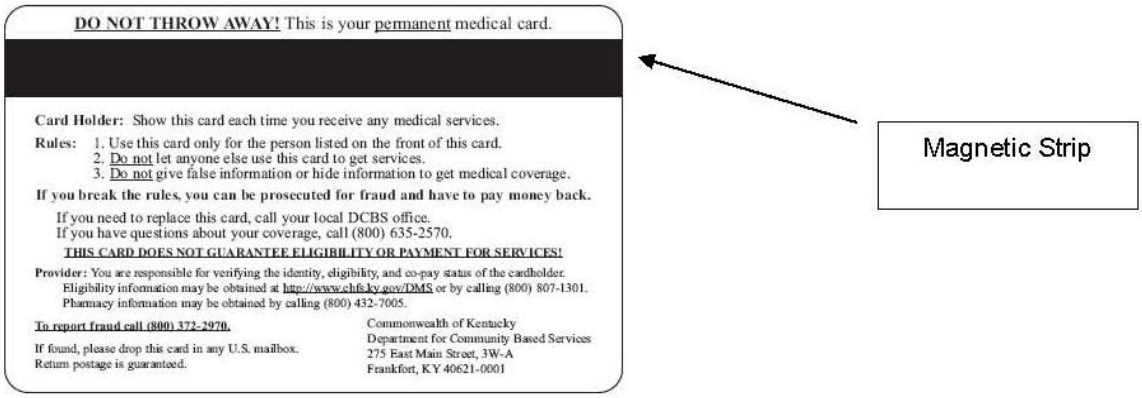
Members should apply for Medicaid eligibility through their local Department for Community Based Services (DCBS) office. Members with questions or concerns can contact Member Services at 1-800-635-2570, Monday through Friday. This office is closed on Holidays.

The primary identification for Medicaid-eligible members is the Kentucky Medicaid card. This is a permanent plastic card issued when the Member becomes eligible for Medicaid coverage. The name of the member and the member's Medicaid ID number are displayed on the card. The provider is responsible for checking identification and verifying eligibility before providing services.

NOTE: Payment cannot be made for services provided to ineligible members; and possession of a Member Identification card does not guarantee payment for all medical services.

1.2.1 Plastic Swipe KY Medicaid Card





Through a vendor of your choice, the magnetic strip can be swiped to obtain eligibility information.

Providers who wish to utilize the card's magnetic strip to access eligibility information may do so by contracting with one of several vendors.

1.2.2 Member Eligibility Categories

1.2.2.1 QMB and SLMB

Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB) are Members who qualify for both Medicare and Medicaid. In some cases, Medicaid may be limited. A QMB Member's card shows "QMB" or "QMB Only." QMB Members have Medicare and full Medicaid coverage, as well. QMB-only Members have Medicare, and Medicaid serves as a Medicare supplement only. A Member with SLMB does not have Medicaid coverage; Kentucky Medicaid pays a "buy-in" premium for SLMB Members to have Medicare, but offers no claims coverage.

1.2.2.2 Managed Care Partnership

Passport is a healthcare plan serving Kentucky Medicaid members who live in the following counties: Breckinridge, Bullitt, Carroll, Grayson, Hardin, Henry, Jefferson, Larue, Marion, Meade, Nelson, Oldham, Shelby, Spencer, Trimble, and Washington.

The other Managed Care Plans servicing Kentucky Medicaid members are WellCare of Kentucky, Kentucky Spirit Health Plan and CoventryCares of Kentucky. These plans are not county regional as Passport indicated above.

Medical benefits for persons whose care is overseen by an MCO are similar to those of Kentucky Medicaid, but billing procedures and coverage of some services may differ. Providers with Managed Care plan questions should contact: Passport Provider Services at 1-800-578-0775, WellCare of Kentucky at 1-877-389-9457, Kentucky Spirit Health Plan at 1-866-643-3153 and CoventryCares of Kentucky at 1-855-300-5528.

1.2.2.3 KCHIP

The Kentucky Children's Health Insurance Program (KCHIP) provides coverage to children through age 18 who have no insurance and whose household income meets program guidelines. Children with KCHIP III are eligible for all Medicaid-covered services except Non-Emergency Transportation and EPSDT Special Services. Regular KCHIP children are eligible for all Medicaid-covered services.

For more information, access the KCHIP website at http://kidshealth.ky.gov/en/kchip.

1.2.2.4 Presumptive Eligibility

Presumptive Eligibility (PE) is a program which offers pregnant women temporary medical coverage for prenatal care. A treating physician may issue an Identification Notice to a woman after pregnancy is confirmed. Presumptive Eligibility expires 90 days from the date the Identification Notice is issued, but coverage will not extend beyond three calendar months. This short-term program is only intended to allow a woman to have access to prenatal care while she is completing the application process for full Medicaid benefits.

1.2.2.4.1 Presumptive Eligibility Definitions

Presumptive Eligibility (PE) is designed to provide coverage for ambulatory prenatal services when the following services are provided by approved health care providers.

A. SERVICES COVERED UNDER PE

- Office visits to a Primary Care Provider (see list below) and/or Health Department
- Laboratory Services

- Diagnostic radiology services (including ultrasound)
- General dental services
- Emergency room services
- Transportation services (emergency and non-emergency)
- Prescription drugs (including prenatal vitamins)

B. DEFINITION OF PRIMARY CARE PROVIDER – Any health care provider who is enrolled as a KY Medicaid provider in one of the following programs:

- Physician/osteopaths practicing in the following medical specialties:
  - Family Practice
  - Obstetrics/Gynecology
  - General Practice
  - Pediatrics
  - Internal Medicine
- Physician Assistants
- Nurse Practitioners/ARNP's
- Nurse Midwives
- Rural Health Clinics
- Primary Care Centers
- Public Health Departments

C. SERVICES NOT COVERED UNDER PE

- Office visits or procedures performed by a specialist physician (those practicing in a specialty other than what is listed in Section B above), even if that visit/procedure is determined by a qualified PE primary care provider to be medically necessary
- Inpatient hospital services, including labor, delivery and newborn nursery services;
- Mental health/substance abuse services
- Any other service not specifically listed in Section A as being covered under PE
- Any services provided by a health care provider who is not recognized by the Department for Medicaid Services (DMS) as a participating provider

1.2.2.5 Breast & Cervical Cancer Treatment Program

Breast and Cervical Cancer Treatment Program (BCCTP) offers Medicaid coverage to women who have a confirmed cancerous or pre-cancerous condition of the breast or cervix. In order to

qualify, women must be screened and diagnosed with cancer by the Kentucky Women's Cancer Screening Program, be between the ages of 21 to 65, have no other insurance coverage, and not reside in a public institution. The length of coverage extends through active treatment for the breast or cervical cancer condition. Those members receiving Medicaid through the Breast and Cervical Cancer Program are entitled to full Medicaid services. Women who are eligible through PE or BCCTP do not receive a medical card for services. The enrolling provider will give a printed document that is to be used in place of a card.

1.2.3 Verification of Member Eligibility

This section covers:

- Methods for verifying eligibility;
- How to verify eligibility through an automated 800 number function;
- How to use other proofs to determine eligibility; and,
- What to do when a method of eligibility is not available.

1.2.3.1 Obtaining Eligibility and Benefit Information

Eligibility and benefit information is available to providers via the following:

- Voice Response Eligibility Verification (VREV) available 24 hours/7 days a week at 1-800-807-1301;
- KYHealth-Net at http://www.chfs.ky.gov/dms/kyhealth.htm
- The Department for Medicaid Services, Member Eligibility Branch at 1-800-635-2570, Monday through Friday, except Holidays.

1.2.3.1.1 Voice Response Eligibility Verification (VREV)

HP Enterprise Services maintains a Voice Response Eligibility Verification (VREV) system that provides member eligibility verification, as well as third party liability (TPL) information, Managed Care, PRO review, Card Issuance, Co-pay, provider check write, and claim status information.

The VREV system generally processes calls in the following sequence:

1. Greet the caller and prompt for mandatory provider ID.
2. Prompt the caller to select the type of inquiry desired (eligibility, check amount, claim status, and so on).
3. Prompt the caller for the dates of service (enter four digit year, for example, MMDDCCYY).
4. Respond by providing the appropriate information for the requested inquiry.
5. Prompt for another inquiry.
6. Conclude the call.

This system allows providers to take a shortcut to information. Users may key the appropriate responses (such as provider ID or Member number) as soon a each prompt begins. The number of inquiries is limited to five per call. The VREV spells the member name and

announces the dates of service. Check amount data is accessed through the VREV voice menu. The Provider's last three check amounts are available.

The telephone number (for use by touch-tone phones only) for the VREV is 1-800-807-1301. The VREV system cannot be accessed via rotary dial telephones.

1.2.3.1.2 KYHealth-Net Online Member Verification

KYHEALTH-NET ONLINE ACCESS CAN BE OBTAINED AT:

http://www.chfs.ky.gov/dms/kyhealth.htm

The KyHealth Net website is designed to provide real-time access to member information. A User Manual is available for downloading and is designed to assist providers in system navigation. Providers with suggestions, comments, or questions, should contact the HP Enterprise Services Electronic Claims Department at KY_EDI_Helpdesk@hp.com.

All Member information is subject to HIPAA privacy and security provisions, and it is the responsibility of the provider and the provider's system administrator to ensure all persons with access understand the appropriate use of this data. It is suggested that providers establish office guidelines defining appropriate and inappropriate uses of this data.

2 Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI) is structured business-to-business communications using electronic media rather than paper.

2.1 How To Get Started

All Providers are encouraged to utilize EDI rather than paper claims submission. To become a business-to-business EDI Trading Partner or to obtain a list of Trading Partner vendors, contact the HP Enterprise Services Electronic Data Interchange Technical Support Help Desk at:

HP Enterprise Services
P.O. Box 2016
Frankfort, KY 40602-2016

1-800-205-4696

Help Desk hours are between 7:00 a.m. and 6:00 p.m. Monday through Friday, except holidays.

2.2 Format and Testing

All EDI Trading Partners must test successfully with HP Enterprise Services and have Department for Medicaid Services (DMS) approved agreements to bill electronically before submitting production transactions. Contact the EDI Technical Support Help Desk at the phone number listed above for specific testing instructions and requirements.

2.3 ECS Help

Providers with questions regarding electronic claims submission may contact the EDI Help desk.

2.4 Companion Guides for Electronic Claims (837) Transactions

837 Companion Guides are available at:

http://www.kymmis.com/kymmis/Companion%20Guides/index.aspx

3 KyHealth Net

The KyHealth Net website allows providers to submit claims online via a secure, direct data entry function. Providers with internet access may utilize the user-friendly claims wizard to submit claims, in addition to checking eligibility and other helpful functions.

3.1 How To Get Started

All Providers are encouraged to utilize KyHealth Net rather than paper claims submission. To become a KyHealthNet user, contact our EDI helpdesk at 1-800-205-4696, or click the link below.

http://www.chfs.ky.gov/dms/kyhealth.htm

3.2 KyHealth Net Companion Guides.

Field-by-field instructions for KyHealth Net claims submission are available at:

http://www.kymmis.com/kymmis/Provider%20Relations/KYHealthNetManuals.aspx

4 General Billing Instructions for Paper Claim Forms

4.1 General Instructions

The Department for Medicaid Services is mandated by the Centers for Medicare and Medicaid Services (CMS) to use the appropriate form for the reimbursement of services. Claims may be submitted on paper or electronically.

4.2 Imaging

All paper claims are imaged, which means a digital photograph of the claim form is used during claims processing. This streamlines claims processing and provide efficient tools for claim resolution, inquiries, and attendant claim related matters.

By following the guidelines below, providers can ensure claims are processed as they intend:

- USE BLACK INK ONLY;
- Do not use glue;
- Do not use more than one staple per claim;
- Press hard to guarantee strong print density if claim is not typed or computer generated;
- Do not use white-out or shiny correction tape; and,
- Do not send attachments smaller than the accompanying claim form.

4.3 Optical Character Recognition

Optical Character Recognition (OCR) eliminates human intervention by sending the information on the claim directly to the processing system, bypassing data entry. OCR is used for computer generated or typed claims only. Information obtained mechanically during the imaging stage does not have to be manually typed, thus reducing claim processing time. Information on the claim must be contained within the fields using font 10 as the recommended font size in order for the text to be properly read by the scanner.

5 Additional Information and Forms

5.1 Claims with Dates of Service More than One Year Old

In accordance with federal regulations, claims must be received by Medicaid no more than 12 months from the date of service, or six months from the Medicare or other insurance payment date, whichever is later. "Received" is defined in 42 CFR 447.45 (d) (5) as "The date the agency received the claim as indicated by its date stamp on the claim."

Kentucky Medicaid includes the date received in the Internal Control Number (ICN). The ICN is a unique number assigned to each incoming claim and the claim's related documents during the data preparation process. Refer to Appendix A for more information about the ICN.

For claims more than 12 months old to be considered for processing, the provider must attach documentation showing timely receipt by DMS or HP Enterprise Services and documentation showing subsequent billing efforts, if any.

To process claims beyond the 12 month limit, you must attach to each claim form involved, a copy of a Claims in Process, Paid Claims, or Denied Claims section from the appropriate Remittance Statement no more than 12 months old, which verifies that the original claim was received within 12 months of the service date.

Additional documentation that may be attached to claims for processing for possible payment is:

- A screen print from KYHealth-Net verifying eligibility issuance date and eligibility dates must be attached behind the claim;
- A screen print from KYHealth-Net verifying filing within 12 months from date of service, such as the appropriate section of the Remittance Advice or from the Claims Inquiry Summary Page (accessed via the Main Menu's Claims Inquiry selection);
- A copy of the Medicare Explanation of Medicare Benefits received 12 months after service date but less than six months after the Medicare adjudication date; and,
- A copy of the commercial insurance carrier's Explanation of Benefits received 12 months after service date but less than six months after the commercial insurance carrier's adjudication date.

5.2 Retroactive Eligibility (Back-Dated) Card

Aged claims for Members whose eligibility for Medicaid is determined retroactively may be considered for payment if filed within one year from the eligilbility issuance date. Claim submission must be within 12 months of the issuance date. A copy of the KYHealth-Net card issuance screen must be attached behind the paper claim.

5.3 Unacceptable Documentation

Copies of previously submitted claim forms, providers' in-house records of claims submitted, or letters detailing filing dates are not acceptable documentation of timely billing. Attachments must prove the claim was received in a timely manner by HP Enterprise Services.

5.4 Third Party Coverage Information

5.4.1 Commercial Insurance Coverage (this does NOT include Medicare)

When a claim is received for a Member whose eligibility file indicates other health insurance is active and applicable for the dates of services, and no payment from other sources is entered on the Medicaid claim form, the claim is automatically denied unless documentation is attached.

5.4.2 Documentation That May Prevent A Claim from Being Denied for Other Coverage

The following forms of documentation prevent claims from being denied for other health insurance when attached to the claim.

1. Remittance statement from the insurance carrier that includes:
    - Member name;
    - Date(s) of service;
    - Billed information that matches the billed information on the claim submitted to Medicaid; and,
    - An indication of denial or that the billed amount was applied to the deductible.

NOTE: Rejections from insurance carriers stating "additional information necessary to process claim" is not acceptable.

2. Letter from the insurance carrier that includes:
    - Member name;
    - Date(s) of service(s);
    - Termination or effective date of coverage (if applicable);
    - Statement of benefits available (if applicable); and,
    - The letter must have a signature of an insurance representative, or be on the insurance company's letterhead.
3. Letter from a provider that states they have contacted the insurance company via telephone. The letter must include the following information:
    - Member name;
    - Date(s) of service;
    - Name of insurance carrier;
    - Name of and phone number of insurance representative spoken to or a notation indicating a voice automated response system was reached;
    - Termination or effective date of coverage; and,
    - Statement of benefits available (if applicable).
4. A copy of a prior remittance statement from an insurance company may be considered an acceptable form of documentation if it is:

- For the same Member;
- For the same or related service being billed on the claim; and,
- The date of service specified on the remittance advice is no more than six months prior to the claim's date of service.

NOTE: If the remittance statement does not provide a date of service, the denial may only be acceptable by HP Enterprise Services if the date of the remittance statement is no more than six months from the claim's date of service.

5. Letter from an employer that includes:
   - Member name;
   - Date of insurance or employee termination or effective date (if applicable); and,
   - Employer letterhead or signature of company representative.

5.4.3 When there is no response within 120 days from the insurance carrier

When the other health insurance has not responded to a provider's billing within 120 days from the date of filing a claim, a provider may complete a TPL Lead Form. Write "no response in 120 days" on either the TPL Lead Form or the claim form, attach it to the claim and submit it to HP Enterprise Services. HP Enterprise Services overrides the other health insurance edits and forwards a copy of the TPL Lead form to the TPL Unit. A member of the TPL staff contacts the insurance carrier to see why they have not paid their portion of liability.

5.4.4 For Accident And Work Related Claims

For claims related to an accident or work related incident, the provider should pursue information relating to the event. If an employer, individual, or an insurance carrier is a liable party but the liability has not been determined, claims may be submitted to HP Enterprise Services with an attached letter containing any relevant information, such as, names of attorneys, other involved parties and/or the Member's employer to:

HP Enterprise Services

ATTN: TPL Unit

P.O. Box 2107

Frankfort, KY 40602-2107

5.4.4.1 TPL Lead Form

HP Enterprise Services

HP Enterprise Services
Attention: TPL Unit
P.O. Box 2107
Frankfort, KY 40602-2107

Third Party Liability Lead Form

Provider Name:_____ Provider #:_____

Member Name:_____ Member #:_____

Address:_____ Date of Birth:_____

From Date of Service:_____ To Date of Service:_____

Date of Admission:_____ Date of Discharge:_____

Insurance Carrier Name:_____

Address:_____

Policy Number:_____ Start Date:_____ End Date:_____

Date Claim Was Filed with Insurance Carrier:_____

Please check the one that applies:

_____ No Response in Over 120 Days

_____ Policy Termination Date: _____

_____ Other: Please explain in the space provided below

_____
_____
_____
_____

Contact Name:_____ Contact Telephone #:_____

Signature:_____ Date:_____

DMS Approved: January 10, 2011

5.5 Provider Inquiry Form

Provider Inquiry Forms may be used for any unique questions concerning claim status; paid or denied claims; and billing concerns. The mailing address for the Provider Inquiry Form is:

HP Enterprise Services

Provider Services

P.O. Box 2100

Frankfort, KY 40602-2100

Please keep the following points in mind when using this form:

- Send the completed form to HP Enterprise Services. A copy is returned with a response;
- When resubmitting a corrected claim, do not attach a Provider Inquiry Form;
- A toll free HP Enterprise Services number **1-800-807-1232** is available in lieu of using this form; and,
- To check claim status, call the HP Enterprise Services Voice Response on **1-800-807-1301**.

Provider Inquiry Form

HP Enterprise Services Corporation

Post Office Box 2100

Frankfort, KY 40602-2100

Did you know that electronic claim submission can reduce your processing time significantly? You can also check claim status, verify eligibility, download remittance advices, and many other functions. Go to www.kymmis.com or contact Billing Inquiry at 1-800-807-1232 for more information. You may also send an inquiry via e-mail at ky_provider_inquiry@hp.com

1. Provider Number	3. Member Name (first, last)	
2. Provider Name and Address	4. Medical Assistance Number	
	5. Billed Amount	6. Claim Service Date
7. Email	8.ICN (if applicable)	

. Provider's Message

10.

Signature Date

HP Enterprise Services Response: OFFICE USE ONLY

_____This claim has been resubmitted for possible payment.

_____This claim paid on _____in the amount of _____

_____This claim was denied on _____with EOB code_____

_____ Aged claim. Please see attached documentation concerning services submitted past the 12 month filing limit.

Other: _____

_____

Signature Date

_____

HIPAA Privacy Notification: This message and accompanying documents are covered by the Communications Privacy Act, 18 U.S.C. 2510-2521, and contain information intended for the specified individual(s) only. This information is confidential. If you are not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, copying, or the taking of any action based on the contents of this information is strictly prohibited. If you have received this communication in error, please notify us immediately and delete the original message.

5.6 Prior Authorization Information

- The prior authorization process does NOT verify anything except medical necessity. It does not verify eligibility nor age.
- The prior authorization letter does not guarantee payment. It only indicates that the service is approved based on medical necessity.
- If the individual does not become eligible for Kentucky Medicaid, loses Kentucky Medicaid eligibility, or ages out of the program eligibility, services will not be reimbursed despite having been deemed medically necessary.
- Prior Authorization should be requested prior to the provision of services except in cases of:
    - Retro-active Member eligibility
    - Retro-active provider number
- Providers should always completely review the Prior Authorization Letter prior to providing services or billing.

Access the KYHealth Net website to obtain blank Prior Authorization forms.

http://www.kymmis.com/kymmis/Provider%20Relations/PriorAuthorizationForms.aspx

Access to Electronic Prior Authorization request (EPA).

https://home.kymmis.com

5.7 Adjustments And Claim Credit Requests

An adjustment is a change to be made to a “PAID” claim. The mailing address for the Adjustment Request form is:

HP Enterprise Services

P.O. Box 2108

Frankfort, KY 40602-2108

Attn: Financial Services

Please keep the following points in mind when filing an adjustment request:

- Attach a copy of the corrected claim and the paid remittance advice page to the adjustment form. For a Medicaid/Medicare crossover, attach an EOMB (Explanation of Medicare Benefits) to the claim;
- Do not send refunds on claims for which an adjustment has been filed;
- Be specific. Explain exactly what is to be changed on the claim;
- Claims showing paid zero dollar amounts are considered paid claims by Medicaid. If the paid amount of zero is incorrect, the claim requires an adjustment; and,
- An adjustment is a change to a paid claim; a claim credit simply voids the claim entirely.

HP Enterprise Services

ADJUSTMENT AND CLAIM CREDIT REQUEST FORM

MAIL TO: HP Enterprise Services
P.O. BOX 2108
FRANKFORT, KY 40602-2108
1-800-807-1232
ATTN: FINANCIAL SERVICES

NOTE: **A CLAIM CREDIT VOIDS THE CLAIM ICN FROM THE SYSTEM -- A "NEW DAY" CLAIM MAY BE SUBMITTED, IF NECESSARY. THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A CORRECTED CLAIM AND REMITTANCE ADVICE TO ADJUST A CLAIM.**

<table>
<tr><td colspan="2">CHECK APPROPRIATE BOX:
CLAIM ADJUSTMENT ☐ CLAIM CREDIT ☐</td><td colspan="2">1. Original Internal Control Number (ICN)</td></tr>
<tr><td colspan="2">2. Member Name</td><td colspan="2">3. Member Medicaid Number</td></tr>
<tr><td rowspan="2">4. Provider Name and Address</td><td>5. Provider</td><td>6. From Date of Service</td><td>7. To Date of Service</td></tr>
<tr><td>8. Original Billed Amount</td><td>9. Original Paid Amount</td><td>10. Remittance Advice Date</td></tr>
</table>

11. Please specify **WHAT** is to be adjusted on the claim. You must explain in detail in order for an adjustment specialist to understand what needs to be accomplished by adjusting the claim.

_____

_____

12. Please specify the **REASON** for the adjustment or claim credit request.

_____

_____

_____

13. Signature _____ 14. Date _____

DMS Approved: January 10, 2011

5.8 Cash Refund Documentation Form

The Cash Refund Documentation Form is used when refunding money to Medicaid. The mailing address for the Cash Refund Form is:

HP Enterprise Services

P.O. Box 2108

Frankfort, KY 40602-2108

Attn: Financial Services

Please keep the following points in mind when refunding:

- Attach the Cash Refund Documentation Form to a check made payable to the KY State Treasurer.
- Attach applicable documentation, such as a copy of the remittance advice showing the claim for which a refund is being issued.
- If refunding all claims on an RA, the check amount must match the total payment amount on the RA. If refunding multiple RAs, a separate check must be issued for each RA.

HP Enterprise Services

Mail To: *HP Enterprise Services*
P.O. Box 2108
Frankfort, KY 40602-2108
ATTN: Financial Services

CASH REFUND DOCUMENTATION

1. Check Number		**2. Check Amount**
3. Provider Name/ID /Address		**4. Member Name**
		5. Member Number
6. From Date of Service	**7. To Date of Service**	**8. RA Date**

9. Internal Control Number (If several ICNs, attach RAs)

Research for Refund: (Check appropriate blank)

_____ **a.** **Payment from other source - Check the category and list name** *(attach copy of EOB)*
- _____ **Health Insurance**
- _____ **Auto Insurance**
- _____ **Medicare Paid**
- _____ **Other**

_____ **b.** **Billed in error**

_____ **c.** **Duplicate payment (attach a copy of both RAs)**
If RAs are paid to two different providers, specify to which provider ID the check is to be applied.

_____ **d.** **Processing error OR overpayment (explain why)**

_____ **e.** **Paid to wrong provider**

_____ **f.** **Money has been requested - date of the letter** ____
(attach a copy of letter requesting money)

_____ **g.** **Other** _____

Contact Name _____ **Phone** _____

DMS Approved: January 10, 2011

5.9 Return To Provider Letter

Claims and attached documentation received by HP Enterprise Services are screened for required information (listed below). If the required information is not complete, the claim is returned to the provider with a “Return to Provider Letter” attached explaining why the claim is being returned.

A claim is returned before processing if the following information is missing:

- Provider ID;
- Member Identification number;
- Member first and last names; and,
- EOMB for Medicare/Medicaid crossover claims.

Other reasons for return may include:

- Illegible claim date of service or other pertinent data;
- Claim lines completed exceed the limit; and,
- Unable to image.

HP

RETURN TO PROVIDER LETTER

Date: _____ - _____ - _____

Dear Provider,
The attached claim is being returned for the following reason(s). These items require correction before the claim can be processed.

01) ___ PROVIDER NUMBER – A valid 8-digit provider number must be on the claim form in the appropriate field.
___ Missing ___ Not a valid provider number

02) ___ PROVIDER SIGNATURE – All claims require an original signature in the provider signature block. The Provider signature cannot be stamped or typed on the claim.
___ Missing
___ Typed signature not valid
___ Stamped signature not valid.

03) ___ Detail lines exceed the limit for claim type.

04) ___ UNABLE TO IMAGE OR KEY – Claim form/EOMB must be legible. Highlighted forms cannot be accepted. Please resubmit on a new form.
___ Print too light ___ Print too dark ___ Highlighted data fields ___ Not legible ___ Dark copy

05) ___ Medicaid **does not** make payment when Medicare has paid the amount in full.

06) ___ The Recipient's Medicaid (MAID) number is missing

07) ___ Medicare EOMB does not match the claim
___Dates of Service _____Recipient Number ____Charges ____ Balance due in Block 30

08) __Other Reason-

_____ Claims are being returned to you for correction for the reasons noted above.

Helpful Hints When Billing for Services Provided to a Medicaid Recipient

- The Recipient's Medicaid number on the HCFA must be entered Field 9A
- The Recipient's Medicaid number on the UB92 must be entered in Block 60
- Medicare numbers **are not** valid Medicaid numbers
- Please refer to your billing manual if you have any concerns about billing the Medicaid program correctly.

Please make the necessary corrections and resubmit for processing. If you have any questions, please feel free to contact our Provider Relations Group, open Monday through Friday, 8:00 a.m. until 6:00 p.m. eastern standard/daylight savings time, at 1-800-807-1232.

If you are interested in billing Medicaid electronically please contact EDS at 1-800-205-4696 7:30 AM to 6PM Monday through Friday except holidays.

Initials of clerk _____

Provider Name _____

Provider Number _____

Reason Code _____

5.10 Provider Representative List

5.10.1 Phone Numbers and Assigned Counties

JACKIE RICHIE 502-209-3100 Extension 2021273 jackie.richie@hp.com			VICKY HICKS 502-209-3100 Extension 2021263 vicky.hicks@hp.com			PENNY GERMINARO 502-209-3100 Extension 2021281 penny.germinaro@hp.com
Assigned Counties			Assigned Counties			Assigned Counties
ADAIR	HARLAN	MCLEAN	ANDERSON	GRAYSON	MERCER	ALLEN
BALLARD	HENDERSON	MCCREARY	BATH	GREENUP	MONTGOMERY	BARREN
BELL	HICKMAN	METCALFE	BOURBON	HANCOCK	MORGAN	BOONE
BOYLE	HOPKINS	MONROE	BOYD	HARDIN	NELSON	CAMPBELL
BREATHITT	JACKSON	MUHLENBERG	BRACKEN	HARRISON	NICHOLAS	CARROLL
BULLITT	JEFFERSON	OLDHAM	BRECKINRIDGE	JESSAMINE	OHIO	EDMONSON
CALDWELL	KNOTT	OWSLEY	BUTLER	JOHNSON	POWELL	GALLATIN
CALLOWAY	KNOX	PERRY	CARTER	LAWRENCE	ROBERTSON	GRANT
CARLISLE	LARUE	PIKE	CLARK	LEE	ROWAN	HART
CASEY	LAUREL	PULASKI	DAVIESS	LEWIS	SHELBY	HENRY
CHRISTIAN	LESLIE	ROCKCASTLE	ELLIOTT	MADISON	SPENCER	KENTON
CLAY	LETCHER	RUSSELL	ESTILL	MAGOFFIN	WASHINGTON	OWEN
CLINTON	LINCOLN	TAYLOR	FAYETTE	MARTIN	WOLFE	PENDLETON
CRITTENDEN	LIVINGSTON	TODD	FLEMING	MASON	WOODFORD	SCOTT
CUMBERLAND	LOGAN	WAYNE	FRANKLIN	MEADE		SIMPSON
FLOYD	LYON	WHITLEY	GARRARD	MENIFEE		TRIMBLE
FULTON	MARION	TRIGG				WARREN
GRAVES	MARSHALL	UNION				
GREEN	MCCRACKEN	WEBSTER				

- **NOTE – Out-of-state providers contact the Representative who has the county closest bordering their state, unless noted above.**
- **Provider Relations 1-800-807-1232**

6 Form Requirements

Additional forms may be required for reimbursement of Nursing Facility Services or Intermediate Care Facility/Mental Retardation Services. Some of the forms are, but may not be limited to, the following:

- MAP-24
  Memorandum to the Department for Community Based Services

- MAP-552
  Notice of Available Income for Long Term Care

Note: MAP-552s are issued through the Member's local Department for Community Based Services (DCBS) office. This form is not completed by the provider, but the member must have a current form on file.

- MAP-573
  Request Form for Drugs Prior-Authorized for Nursing Facility Members

- MAP-350
  Long Term Care Facilities and Home and Community Based Program Certification Form

Forms can be obtained by accessing the following website:

http://www.kymmis.com, select Provider Relations and then Forms

6.1 MAP-552 – Notice Of Available Income For Long Term Care

MAP-552p
(03/98)

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR SOCIAL INSURANCE

NOTICE OF AVAILABILITY OF INCOME FOR LONG TERM CARE/WAIVER AGENCY/HOSPICE

MEMBER IDENTIFICATION NUMBER:_____ ( ) CORRECTION
( ) INITIAL
( ) CHANGE

PROGRAM: _____

CLIENT'S NAME:_____ DATE OF BIRTH:_____

PROVIDER NUMBER:_____

ADMISSION DATE:_____ DISCHARGE DATE:_____ DEATH DATE:_____

LEVEL OF CARE_____ LTC INELIGIBLE DATE:_____

FAMILY STATUS:_____ SPOUSE STATUS:_____

INCOME COMPUTATION:

UNEARNED INCOME SOURCE	AMOUNT	
RSDI	$_____	
SSI	$_____	
RR	$_____	
VA	$_____	
STATE SUPPLEMENTATION	$_____	
OTHER	$_____	
SUB-TOTAL UNEARNED INC.	$_____	
		CASE STATUS
EARNED INCOME	AMOUNT	ACTIVE CASE:_____
WAGES	$_____	IF ACTIVE, EFF. MA DATE:_____
EARNED INC. DEDUCTION	$_____	IF DISC. EFF. MA DATE:_____
SUB-TOTAL EARNED INC.	$_____	
TOTAL INCOME	$_____	NOTIF. FORM:_____
		NOTIF. FORM DATE:_____
DEDUCTIONS	AMOUNT	
PERSONAL NEEDS ALLOWANCE	$_____	EFF. DATE OF CORR:_____
INCREASED PNA	$_____	ENDING DATE OF CORR:_____
SPOUSE/FAMILY MAINT.	$_____	
SMI	$_____	PRIVATE PAY PATIENT
HEALTH INS	$_____	FROM:_____ THRU_____
INCURRED MEDICAL EXPENSES	$_____	
TOTAL DEDUCTIONS	$_____	
VA AID AND ATTENDANCE	$_____	
THIRD PARTY PAYMENTS	$_____	
AVAILABLE INCOME	$_____	
AVAILABLE INCOME (ROUNDED)	$_____	
AVAILABLE MONTHLY INCOME	$_____	EFFECTIVE DATE:_____

WORKER CODE:_____ CASELOAD CODE:_____ UPDATE DATE:_____

6.2 MAP-350 NF (3/2009)

6.2.1 Long Term Care Facilities and Home and Community Based Program Certification Form

MAP-350 NF (3/2009) Department for Medicaid for Services

DIVISION OF HEALTHCARE FACILITIES MANAGEMENT

MAP – 350 NF INSTRUCTIONS

Purpose of MAP – 350 NF

Center for Medicare and Medicaid Services (CMS) requires that all individuals seeking admission to a nursing facility, ICF/MR/DD facility or a Home and Community Based (HCB) waiver program be given the choice of receiving services in an institution or through Home and Community Based Services.

The MAP – 350 NF is to document that each Medicaid recipient has been given the choice of receiving care in an institution or in a Home and Community Based (HCB) waiver program.

The MAP – 350 NF is required to be completed for each Medicaid recipient prior to admission to a nursing facility or an ICF/MR/DD facility, and annually thereafter.

The original copies of the MAP – 350 NF shall be maintained in the medical record. A copy is to be provided to the recipient/legal representative.

Instructions for Completing the MAP – 350 NF Certification Form

---

I. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, BRAIN INJURY WAIVER.

PLEASE NOTE: COMPLETE (A-D) ONLY THE ONE/ONES THAT ARE APPROPRIATE FOR THE RECIPIENT.

A. The HCBS waiver program is for the aged and disabled individual that requires nursing facility level of care.

The recipient/legal representative must check their choice. Consideration for the HCBS program as an alternative to NF placement ***is requested*** _____***;***
is not requested _____***. Sign and date the section.***

B. The Supports for Community Living (SCL) waiver program is for individuals with mental retardation/developmental disabilities that require intermediate care facility for the mentally retarded or developmentally disability (ICF/MR/DD) level of care.

The recipient/legal representative must check their choice. Consideration for the waiver program as an alternative to ICF/MR/DD ***is requested*** _____***;***
is not requested _____***. Sign and date the section, if applicable.***

C. The Model Waiver II program is for individuals that are ventilator dependent and require nursing facility level of care.

The recipient/legal representative must check their choice. Consideration for Model Waiver II program as an alternative to NF placement ***is requested*** _____***;***
is not requested _____***. Sign and date the section, if applicable.***

1

D. The Acquired Brain Injury waiver program is for individuals aged twenty-one (21) to sixty-five (65) that have sustained a traumatic brain injury and require nursing facility level of care.

The recipient/legal representative must check their choice. Consideration for the ABI Waiver Program as an alternative to NF or NF/ABI placement ***is requested _____; is not requested _____. Sign and date the section, if applicable.***

II. FREEDOM OF CHOICE OF PROVIDER

The recipient/legal representative that elected to receive Home and Community Based waiver services shall be informed that services may be requested from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from the Department for Medicaid Services.
Sign and date the section, if applicable.

III. RESOURCE ASSESSMENT CERTIFICATION

The recipient/legal representative must ***sign and date the section*** to certify that they have been informed of the availability of resource assessments to assist with financial planning provided by the Department for Community Based Services (DCBS).

IV. RECIPIENT INFORMATION

- Enter the Medicaid recipient's name as it appears on the current medical assistance identification (MAID) card:
- Enter the full address where recipient lives:
- Enter the phone number of the recipient:
- Enter the ten digit Medicaid number found on the recipient's MAID card:
- Enter the name (if applicable) of the responsible party/legal representative appointed to make decisions for the recipient. This person would have completed/signed the appropriate sections of this form:
- Enter the full address where the responsible party/legal representative (if applicable) lives:
- Enter the phone number for the responsible party/legal representative (if applicable):
- Enter the signature and title of person assisting with completion of the form:
- Enter the name of the agency/facility that the individual assisting with the completions of the form is employed:
- Enter the full address of the agency/facility:

DIVISION OF HEALTHCARE FACILITIES MANAGEMENT

I. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, ACQUIRED BRAIN INJURY WAIVER

A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement ***is requested _____; is not requested _____.***

_____ _____/_____/_____
Signature ***Date***

B. This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD ***is requested _____; is not requested _____.***

_____ _____/_____/_____
Signature ***Date***

C. MODEL WAIVER II - This is to certify that I/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement ***is requested _____; is not requested _____.***

_____ _____/_____/_____
Signature ***Date***

D. ACQUIRED BRAIN INJURY (ABI) WAIVER - This is to certify that I/legal representative have been informed of the ABI Waiver Program. Consideration for the ABI Waiver Program as an alternative to NF or NF/ABI placement ***is requested _____;***
Is not requested _____.

_____ _____/_____/_____
Signature ***Date***

II. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs, I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.

_____/_____/_____
Signature ***Date***

1

III. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost, of resource assessments to assist with financial planning provided by the Department for Community Based Services.

_____/_____/_____

Signature ***Date***

IV. RECIPIENT INFORMATION

Medicaid Recipient's Name: _____

Address of Recipient: _____

_____

Phone: (_____)_____

Medicaid Number: _____

Responsible Party/Legal Representative: _____

Address: _____

_____

Phone: (_____)_____

Signature and Title of Person Assisting with Completion of Form:

_____

Signature ***Title***

Agency/Facility:

_____

Address:

_____

_____

6.3 MAP-24

MAP-24 is required to be sent to the local DCBS office and the Community Based Services Branch of KY Medicaid when a client is terminated.

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

_____
(Date)

MEMORANDUM

TO: Local Office
Department for Community Based Services
Cabinet for Health and Family Services

FROM: _____ Provider #: _____
(Facility/Waiver Agency)

SUBJECT: _____
(Member Name) (Social Security/Medicaid Number)

_____
(Previous Address)

_____
(Responsible Relative's Name & Address)

This is to notify you that the above-referenced member

☐ was admitted to this facility/waiver agency _____
(Date)
is in Title _____ Payment Status, and was placed in a
(XVIII or XIX)

☐ NF bed ☐ ICF/MR/DD bed ☐ MH bed ☐ EPSDT Bed

☐ Home & Community Based Waiver Service ☐ SCL Waiver Service and/or

☐ was discharged from this facility/waiver agency on _____
(Date)
and went to _____,
(Home Address/Name & Address of New Facility/Waiver Agency)
and/or expired on _____.
(Date)

☐ was re-instated to Home & Community Based or SCL waiver services within 60 days of the
NF admission. _____
(Date Re-Instated)

For Home & Community Based waiver Clients only – last date service was provided _____.
(Date)

_____
(Signature)

MAP-24 (Rev. 02/2001)

6.4 MAP-573 – Prior Authorization for Nursing Facility Members

MAP-573 (REV. 12/03)

KENTUCKY MEDICAID PROGRAM REQUEST FORM
FOR DRUGS PRIOR-AUTHORIZED FOR NURSING FACILITY MEMBERS

MEMBER IDENTIFICATION Number	Member Name
Facility Name	Facility Address
Facility Provider Number	

Admission Date_____ Effective Date _____

This certifies that the above member is (is expected to be) in Kentucky Medicaid vendor payment status in a Medicaid certified nursing facility. Prior authorization is requested for the additional drugs that can be prior authorized as a group.

Authorized Representative of Facility _____

This certifies my request that the above named member be authorized to receive drugs prior authorized for nursing facility members.

Name of Physician _____ License Number _____

Signature of Physician _____ Date _____

The facility completes the form and obtains the signature of the physician, retains one (1) copy in the member's records and provides the pharmacy with the remaining two (2) copies. The pharmacy sends the original copy to EDS. After processing, EDS will notify the Pharmacy by letter.

Pharmacy Provider Number	Pharmacy Name
Pharmacy Address	
City/State/Zip	

THIS FORM MUST BE COMPLETED FOR EACH ADMISSION

CAUTION: THE ABOVE MEMBER MUST BE KENTUCKY MEDICAID ELIGIBLE ON THE DATE OF SERVICE VERIFY BY CHECKING THE MEMBER'S MEDICAID CARD. THIS PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT.

Mailroom use	MAP-552 Continuing Income Information not on file Date: _____

6.5 Completion of Prior Authorization for Nursing Facility Members (MAP-573)

Field	Description
Member Identification Number	Enter the KY Medicaid number.
Member Name	Enter the member's name.
Facility Name	Enter the facility name.
Facility Address	Enter the facility address.
Facility Provider Number	Enter the facility provider number.
Admission Date	Enter the member's admission date.
Effective Date	Enter the date the prior authorization starts.
Authorized Representative of Facility	The signature of the facility's authorized representative is required.
Name of Physician	Enter the Physician's name.
License Number	Enter the Physician's license number.
Signature of Physician	The Physician's signature is required.
Date	Enter the date of Physician's signature.
Nursing Facility Services Provider Number	Enter the dispensing Nursing Facility Service's KY Medicaid provider number.
Nursing Facility Services Name	Enter the dispensing Nursing Facility Services name.
Nursing Facility Services Address	Enter the dispensing Nursing Facility Services street address.
City/State/Zip	Enter the dispensing Nursing Facility Services city/state/zip code.
Mailroom use	Please leave the following field for HP Enterprise Services and DMS utilization.
MAP-552 Continuing Income Information not on file	Checked if there is no long term eligibility segment on file for that member.
Date	Date reviewed by medical policy staff.

7 Completion of UB-04 Claim Form With NPI

7.1 UB-04 With NPI Billing Instructions

Following are form locator numbers and form locator instructions for billing nursing facility services on the UB-04 billing form. Only the instructions for form locators required for HP Enterprise Services processing or for Medicaid Program information are included. Instructions for Form Locators not used by HP Enterprise Services or the Medicaid Program can be found in the UB-04 Training Manual. The UB-04 Training Manual may be obtained from the address listed below. You may also obtain the UB-04 billing forms from the address listed below.

Kentucky Hospital Association

P.O. Box 24163

Louisville, KY 40224

Telephone: 1-502-426-6220

The original UB-04 billing form must be sent to:

HP Enterprise Services
P.O. Box 2106
Frankfort, KY 40602-2106

7.2 UB-04 Claim Form With NPI and Taxonomy

Field	Value
1	Provider Name Street Address City or Town ST ZIP AC+Phone Number
3a PAT. CNTL #	Patient Control Number
b. MED. REC. #	
4 TYPE OF BILL	0893
5 FED. TAX NO.	
6 STATEMENT COVERS PERIOD FROM / THROUGH	010107 / 013107
8 PATIENT NAME	
9 PATIENT ADDRESS	
10 BIRTHDATE	01021900
11 SEX	
ADMISSION 12 DATE	010107
13 HR	02
17 STAT	30
31 OCCURRENCE CODE / DATE	11 / 010107
37	09-29-2008
39 VALUE CODES CODE / AMOUNT	a 80 / 31

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
110	BED			31	3,100 00		
0001	PAGE ___ OF ___	CREATION DATE	013107	TOTALS	3,100.00		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A Medicare				30 00		Pay To NPI #
B Medicaid/KyHealth Choices						57 OTHER PRV ID

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A JANE DOE		4000000000		

Field	Value
63 TREATMENT AUTHORIZATION CODES	A Y12345
64 DOCUMENT CONTROL NUMBER	
65 EMPLOYER NAME	
66 DX	123.0
69 ADMIT DX	123.0
70 PATIENT REASON DX	
71 PPS CODE	
72 ECI	
74 PRINCIPAL PROCEDURE CODE / DATE	
76 ATTENDING NPI	NPI Number
LAST / FIRST	JONES / JAMES
77 OPERATING NPI	
78 OTHER NPI	
79 OTHER NPI	
80 REMARKS	P/T 12 N/F
81CC	

UB-04 CMS-1450 APPROVED OMB NO.

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee LIC9213257

7.3 Completion of UB-04 Claim Form With NPI and Taxonomy

7.3.1 Detailed Instructions

Included is a representative sample of codes and/or services that may be covered by KY Medicaid.

Form Locator number	Form Locator Name and Description	
1	**Provider Name, Address and Telephone**	
	Enter the complete name, address, and telephone number (including area code) of the facility.	
3	**Patient Control Number**	
	Enter the patient control number. The first 14 digits (alpha/numeric) appear on the remittance advice as the invoice number.	
4	**Type of Bill**	
	Enter the appropriate code to indicate the type of bill.	
	1st Digit	Enter zero
	2nd Digit (Type of Facility)	6 = ICF/MR 8 = Nursing Facility
	3rd Digit (Bill Classification)	1 = Medicare, Part A, Crossover 2 = Medicare, Part B, Crossover 7 = Medicaid (ICF/MR only) 9 = KY Medicaid (Nursing Facility only)
	4th Digit (Frequency)	1 = Admit through discharge 2 = Interim, first claim 3 = Interim, continuing claim 4 = Interim, final claim
	Examples of Valid Types of Bill for ICF/MR facilities	
	0671	KY Medicaid, Admit through Discharge/Death
	0672	KY Medicaid, Interim bill, First claim
	0673	KY Medicaid, Interim bill, Continuing claim
	0674	KY Medicaid, Interim bill, Final claim
	0621	Medicare Part B, Admit through Discharge/Death
	0622	Medicare Part B, Interim bill, First claim

	0623	Medicare Part B, Interim bill, Continuing claim
	0624	Medicare Part B, Interim bill, Final Claim
	Examples of Valid Types of Bill for Nursing Facilities	
	0891	KY Medicaid, Admit through Discharge/Death
	0892	KY Medicaid, Interim bill, First claim
	0893	KY Medicaid, Interim bill, Continuing claim
	0894	KY Medicaid, Interim bill, Final claim
	0811	Medicare Part A, Admit through Discharge/Death
	0812	Medicare Part A, Interim bill, First claim
	0813	Medicare Part A, Interim bill, Continuing claim
	0814	Medicare Part A, Interim bill, Final claim
	0821	Medicare Part B, Admit through Discharge/Death
	0822	Medicare Part B, Interim bill, First claim
	0823	Medicare Part B, Interim bill, Continuing claim
	0824	Medicare Part B, Interim bill, Final claim
6	**Statement Covers Period**	
	FROM: Enter the beginning date of the billing period covered by this invoice in numeric format (MMDDYY).	
	THROUGH: Enter the last date of the billing period covered by this invoice in numeric format (MMDDYY).	
10	**Date of Birth**	
	Enter the member's date of birth.	
12	**Admission Date**	
	Enter the date on which the Member was admitted to the facility in numeric format (MMDDYY).	
13	**Admission Hour**	
	Enter the code for the time of admission to the facility.	
	Code Structure	

	CODE	TIME A.M.	CODE	TIME P.M.
	00	12:00 – 12:59 midnight	12	12:00 – 12:59 noon
	01	01:00 - 01:59	13	01:00 - 01:59
	02	02:00 - 02:59	14	02:00 - 02:59
	03	03:00 - 03:59	15	03:00 - 03:59
	04	04:00 - 04:59	16	04:00 - 04:59
	05	05:00 - 05:59	17	05:00 - 05:59
	06	06:00 - 06:59	18	06:00 - 06:59
	07	07:00 - 07:59	19	07:00 - 07:59
	08	08:00 - 08:59	20	08:00 - 08:59
	09	09:00 - 09:59	21	09:00 - 09:59
	10	10:00 - 10:59	22	10:00 - 10:59
	11	11:00 - 11:59	23	11:00 - 11:59

17	**Patient Status Code**	
	Enter the appropriate two-digit patient status code indicating the disposition of the member as of the THROUGH date in Form Locator 6.	
	Status Codes Accepted by KY Medicaid	
	01	Discharged to Home or Self Care (Routine Discharge)
	02	Discharged or Transferred to Acute Hospital
	03	Discharged or Transferred to Skilled Nursing Facility (SNF) or NF
	04	Discharged or Transferred to Intermediate Care Facility (ICF)
	05	Discharged or Transferred to Another Type of Institution
	06	Discharged or Transferred to Home Under Care of Organized Home Health Service Organization
	07	Left Against Medical Advice
	10	Discharged or Transferred to Mental Health Center or

		Mental Hospital
	20	Expired
	30	Still a Member
	Note: **Example 1** **When billing discharged or expired patient status codes, the last day of the statement covers period is not a covered day. The calculation of covered days is as follows:** **PS Thru minus From equals Total Days** **02 08/29/2006 - 08/01/2006 = 28** **Example 2** **Billing patient status code 30, still a patient, the last day of the statement covers period is a covered day. The calculation of covered days is as follows:** **PS Thru Minus From Plus Equals Total Days** **30 08/29/2006 - 08/01/0303 + 1 = 29**	
37	**Medicare EOMB Date**	
	Enter the EOMB date from Medicare, if applicable.	
39-41	**Value Codes**	
	80 = Covered Days Enter the total number of covered days from Form Locator 6. Data entered in Form Locator 39 must agree with accommodation units in Form Locator 46. 82 = Coinsurance Days Enter the number of coinsurance days billed to the KY Medicaid during this billing period. 83 = Life Time Reserve Days Enter the Lifetime Reserve days the patient has elected to use for this billing period. A1 = Deductible Payer A Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due. A2 = Coinsurance Payer A Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due. B1 = Deductible Payer B Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due.	

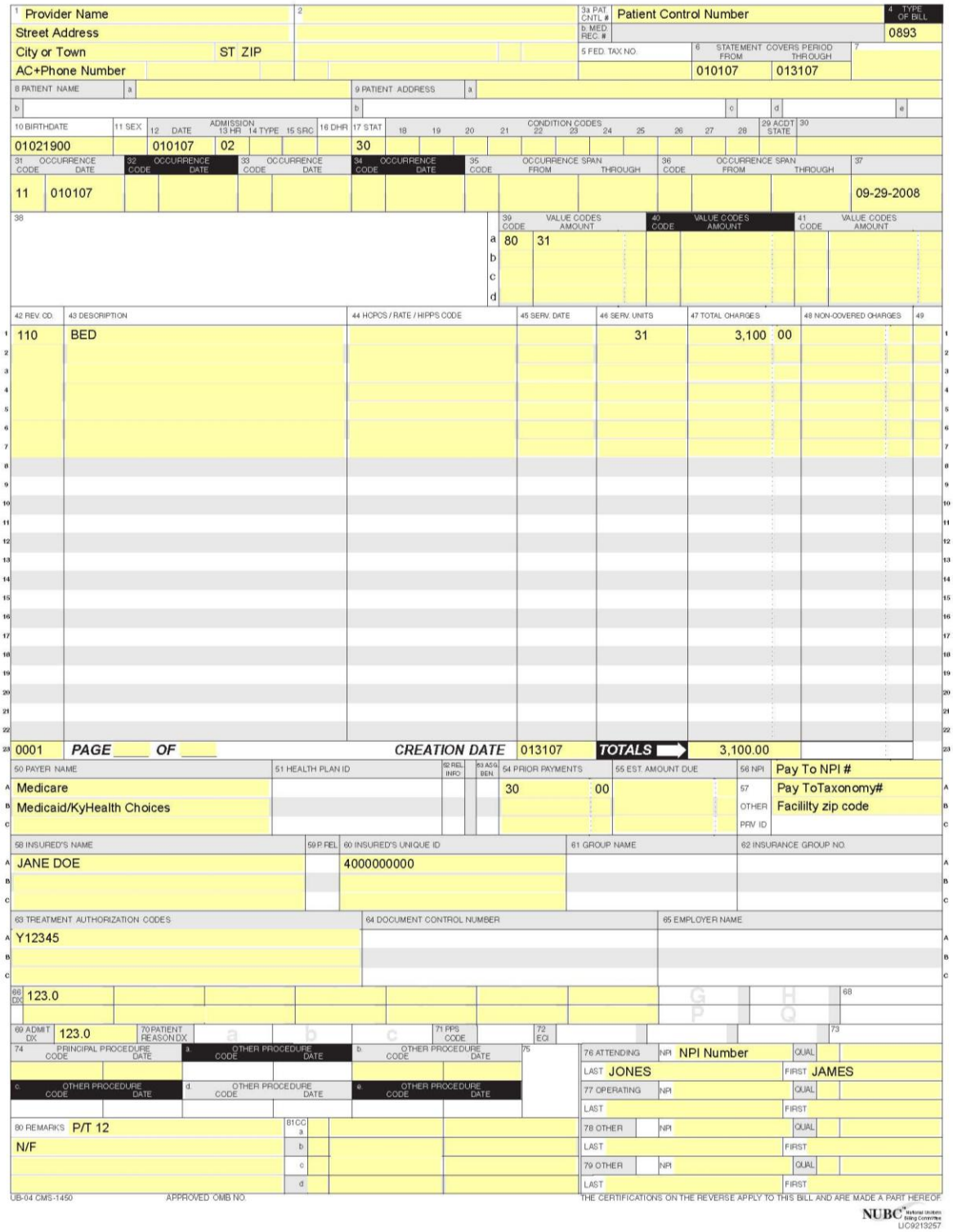
	B2 = Coinsurance Payer B Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due.
42	**Revenue Codes**
	Enter the three-digit revenue code identifying specific accommodation and ancillary services. A list of revenue codes covered by KY Medicaid is located in Appendix A of this manual.
	Description — **Revenue Code** Accommodation — 110,120,130,140,150,160 Bed Reserve - Home/Other* — 180 Bed Reserve - Hospital* — 185 Laboratory — 300 - 314 X-Ray — 320 Oxygen — 410 Physical Therapy — 420 Physical Therapy — 421-424 (PT 11 only) Occupational Therapy — 430 Occupational Therapy — 431-433 (PT 11 only) Speech Therapy — 440 Speech Therapy — 441-444 (PT 11 only) Psychicatric/Psychological Service — 910-918 (PT 11 only) *Bed Reserve days must be billed on separate UB-04 claim forms from in-facility days. **NOTE:** **Total charge Revenue code 0001 must be the final entry in column 42, line 23.** **Total charge amount must be shown in column 47, line 23.**
43	**Description**
	Enter the standard abbreviation assigned to each revenue code.
44	**HCPCS / RATES**
	Enter the appropriate procedure code for the services performed. A detailed description of these codes can be found in Appendix B. (PT 11 is not required to use these codes for billing purposes)
45	**Detail Date of Service (Ancillary Services only)**
	Enter the date of service (MMDDYY format) that the ancillary service is rendered. *Required with revenue codes which begin with 4.
45	**Creation Date**

	Enter the invoice date or invoice creation date.
46	**Unit**
	Enter the quantitative measure of services provided per revenue code.
47	**Total Charges**
	Enter the total charges relating to each revenue code for the billing period. The detailed revenue code amounts must equal the entry "total charges. Claim total must be shown in field 47, line 23.
48	**Non-Covered Charges**
	Enter the charges from Form Locator 47 that are non-payable by KY Medicaid.
50	**Payer Identification**
	Enter the names of payer organizations from which the provider receives payment. For Medicaid, use KY Medicaid. All other liable payers, including Medicare, must be billed first.* * KY Medicaid is payer of last resort. **Note: If you are billing for a replacement policy to Medicare, Medicare needs to be indicated instead of the name of replacement policy.**
54	**Medicare Paid Amount**
	Enter the paid amount from Medicare, if applicable. Enter the amount paid, if any, be a private insurance.
56	**NPI**
	Enter the PAY TO NPI number.
57	**Taxonomy**
	Enter the PAY TO Taxonomy number.
57B	**Other**
	Enter the facilities zip code.
58	**Insured's Name**
	Enter the Member's name in Form Locators 58 A, B, and C that relates to the payer in Form Locators 50 A, B, and C. Enter the Member's name exactly as it appears on the Member Identification card in last name and first name format.

60	**Identification Number**
	Enter the Member Identification number in Form Locators 60 A, B, and C that relates to the Member's name in Form Locators 58 A, B, and C. Enter the 10 digit Member Identification number exactly as it appears on the Member Identification card.
63	**Treatment Authorization Number**
	Enter the 10 digit prior authorization number assigned by Carewise Health, Inc. designating that the treatment covered by the bill is authorized.
67	**Principal Diagnosis Code**
	Enter the ICD-9-CM Vol. 1 and 2 code describing the principal diagnosis.
67A-Q	**Other Diagnosis Code**
	Enter the ICD-9-CM Vol. 1 and 2 codes that co-exist at the time the service is provided.
69	**Admitting Diagnosis**
	Enter the ICD-9-CM diagnosis code describing the admitting diagnosis.
76	**NPI**
	Enter the Attending Physician NPI number.

7.4 UB-04 Claim Form With NPI Alone

NOTE: KY Medicaid advises providers to use this method when a single NPI corresponds to a single KY Medicaid provider ID.



7.5 Completion of UB-04 Claim Form With NPI Alone

7.5.1 Detailed Instructions

Included is a representative sample of codes and/or services that may be covered by KY Medicaid.

NOTE: Those KY Medicaid providers who have a one to one match between the NPI number and the KY Medicaid provider number do not require the use of the Taxonomy when billing. If the NPI number corresponds to more than one KY Medicaid provider number, Taxonomy will be a requirement on the claim.

FORM LOCATOR NUMBER	FORM LOCATOR NAME AND DESCRIPTION	
1	**Provider Name, Address and Telephone**	
	Enter the complete name, address, and telephone number (including area code) of the facility.	
3	**Patient Control Number**	
	Enter the patient control number. The first 14 digits (alpha/numeric) appear on the remittance advice as the invoice number.	
4	**Type of Bill**	
	Enter the appropriate code to indicate the type of bill.	
	1st Digit	Enter zero
	2nd Digit (Type of Facility)	6 = ICF/MR 8 = Nursing Facility
	3rd Digit (Bill Classification)	1 = Medicare, Part A, Crossover 2 = Medicare, Part B, Crossover 7 = Medicaid (ICF/MR only) 9 = KY Medicaid (Nursing Facility only)
	4th Digit (Frequency)	1 = Admit through discharge 2 = Interim, first claim 3 = Interim, continuing claim 4 = Interim, final claim
	Examples of Valid Types of Bill for ICF/MR facilities	
	0671	KY Medicaid, Admit through Discharge/Death
	0672	KY Medicaid, Interim bill, First claim
	0673	KY Medicaid, Interim bill, Continuing claim
	0674	KY Medicaid, Interim bill, Final claim

	0621	Medicare Part B, Admit through Discharge/Death
	0622	Medicare Part B, Interim bill, First claim
	0623	Medicare Part B, Interim bill, Continuing claim
	0624	Medicare Part B, Interim bill, Final Claim
	Examples of Valid Types of Bill for Nursing Facilities	
	0891	KY Medicaid, Admit through Discharge/Death
	0892	KY Medicaid, Interim bill, First claim
	0893	KY Medicaid, Interim bill, Continuing claim
	0894	KY Medicaid, Interim bill, Final claim
	0811	Medicare Part A, Admit through Discharge/Death
	0812	Medicare Part A, Interim bill, First claim
	0813	Medicare Part A, Interim bill, Continuing claim
	0814	Medicare Part A, Interim bill, Final claim
	0821	Medicare Part B, Admit through Discharge/Death
	0822	Medicare Part B, Interim bill, First claim
	0823	Medicare Part B, Interim bill, Continuing claim
	0824	Medicare Part B, Interim bill, Final claim
6	**Statement Covers Period**	
	FROM: Enter the beginning date of the billing period covered by this invoice in numeric format (MMDDYY).	
	THROUGH: Enter the last date of the billing period covered by this invoice in numeric format (MMDDYY).	
10	**Date of Birth**	
	Enter the member's date of birth.	
12	**Admission Date**	
	Enter the date on which the Member was admitted to the facility in numeric format (MMDDYY).	
13	**Admission Hour**	

	Enter the code for the time of admission to the facility.			
	Code Structure			
	CODE	**TIME A.M.**	**CODE**	**TIME P.M.**
	00	12:00 – 12:59 midnight	12	12:00 – 12:59 noon
	01	01:00 - 01:59	13	01:00 - 01:59
	02	02:00 - 02:59	14	02:00 - 02:59
	03	03:00 - 03:59	15	03:00 - 03:59
	04	04:00 - 04:59	16	04:00 - 04:59
	05	05:00 - 05:59	17	05:00 - 05:59
	06	06:00 - 06:59	18	06:00 - 06:59
	07	07:00 - 07:59	19	07:00 - 07:59
	08	08:00 - 08:59	20	08:00 - 08:59
	09	09:00 - 09:59	21	09:00 - 09:59
	10	10:00 - 10:59	22	10:00 - 10:59
	11	11:00 - 11:59	23	11:00 - 11:59

17	**Patient Status Code**	
	Enter the appropriate two-digit patient status code indicating the disposition of the member as of the THROUGH date in Form Locator 6.	
	Status Codes Accepted by KY Medicaid	
	01	Discharged to Home or Self Care (Routine Discharge)
	02	Discharged or Transferred to Acute Hospital
	03	Discharged or Transferred to Skilled Nursing Facility (SNF) or NF
	04	Discharged or Transferred to Intermediate Care Facility (ICF)
	05	Discharged or Transferred to Another Type of Institution
	06	Discharged or Transferred to Home Under Care of Organized Home Health Service Organization

	07	Left Against Medical Advice
	10	Discharged or Transferred to Mental Health Center or Mental Hospital
	20	Expired
	30	Still a Member
	Note: **Example 1** **When billing discharged or expired patient status codes, the last day of the statement covers period is not a covered day. The calculation of covered days is as follows:** **PS Thru minus From equals Total Days** **02 08/29/2006 - 08/01/2006 = 28** **Example 2** **Billing patient status code 30, still a patient, the last day of the statement covers period is a covered day. The calculation of covered days is as follows:** **PS Thru Minus From Plus Equals Total Days** **30 08/29/2006 - 08/01/0303 + 1 = 29**	
37	**Medicare EOMB Date**	
	Enter the EOMB date from Medicare, if applicable.	
39-41	**Value Codes**	
	80 = Covered Days Enter the total number of covered days from Form Locator 6. Data entered in Form Locator 39 must agree with accommodation units in Form Locator 46. 82 = Coinsurance Days Enter the number of coinsurance days billed to the KY Medicaid during this billing period. 83 = Life Time Reserve Days Enter the Lifetime Reserve days the patient has elected to use for this billing period. A1 = Deductible Payer A Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due. A2 = Coinsurance Payer A Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due. B1 = Deductible Payer B	

	Enter the amount as shown on the EOMB to be applied to the Member's deductible amount due. B2 = Coinsurance Payer B Enter the amount as shown on the EOMB to be applied toward Member's coinsurance amount due.
42	**Revenue Codes**
	Enter the three-digit revenue code identifying specific accommodation and ancillary services. A list of revenue codes covered by KY Medicaid is located in Appendix A of this manual.
	Description — **Revenue Code** Accommodation — 110,120,130,140,150,160 Bed Reserve - Home/Other* — 180 Bed Reserve - Hospital* — 185 Laboratory — 300 - 314 X-Ray — 320 Oxygen — 410 Physical Therapy — 420 Physical Therapy — 421-424 (PT 11 only) Occupational Therapy — 430 Occupational Therapy — 431-433 (PT 11 only) Speech Therapy — 440 Speech Therapy — 441-444 (PT 11 only) Psychicatric/Psychological Service — 910-918 (PT 11 only) *Bed Reserve days must be billed on separate UB-04 claim forms from in-facility days. **NOTE:** **Total charge Revenue code 0001 must be the final entry in column 42, line 23.** **Total charge amount must be shown in column 47, line 23.**
43	**Description**
	Enter the standard abbreviation assigned to each revenue code.
44	**HCPCS / RATES**
	Enter the appropriate procedure code for the services performed. A detailed description of these codes can be found in Appendix B. (PT 11 is not required to use these codes for billing purposes)
45	**Detail Date of Service (Ancillary Services only)**
	Enter the date of service (MMDDYY format) that the ancillary service is rendered. *Required with revenue codes which begin with 4.

45	**Creation Date**
	Enter the invoice date or invoice creation date.
46	**Unit**
	Enter the quantitative measure of services provided per revenue code.
47	**Total Charges**
	Enter the total charges relating to each revenue code for the billing period. The detailed revenue code amounts must equal the entry "total charges. Claim total must be shown in field 47, line 23.
48	**Non-Covered Charges**
	Enter the charges from Form Locator 47 that are non-payable by KY Medicaid.
50	**Payer Identification**
	Enter the names of payer organizations from which the provider receives payment. For Medicaid, use KY Medicaid. All other liable payers, including Medicare, must be billed first.* * KY Medicaid is payer of last resort. **Note: If you are billing for a replacement policy to Medicare, Medicare needs to be indicated instead of the name of replacement policy.**
54	**Medicare Paid Amount**
	Enter the paid amount from Medicare, if applicable. Enter the amount paid, if any, be a private insurance.
56	**NPI**
	Enter the PAY TO NPI number.
57	**Taxonomy**
	Enter the PAY TO Taxonomy number.
57B	**Other**
	Enter the facilities zip code.
58	**Insured's Name**
	Enter the Member's name in Form Locators 58 A, B, and C that relates to the payer in Form Locators 50 A, B, and C. Enter the Member's name exactly as it appears on the Member Identification card in last

	name and first name format.
60	**Identification Number**
	Enter the Member Identification number in Form Locators 60 A, B, and C that relates to the Member's name in Form Locators 58 A, B, and C. Enter the 10 digit Member Identification number exactly as it appears on the Member Identification card.
63	**Treatment Authorization Number**
	Enter the 10 digit prior authorization number assigned by Carewise Health, Inc. designating that the treatment covered by the bill is authorized.
67	**Principal Diagnosis Code**
	Enter the ICD-9-CM Vol. 1 and 2 code describing the principal diagnosis.
67A-Q	**Other Diagnosis Code**
	Enter the ICD-9-CM Vol. 1 and 2 codes that co-exist at the time the service is provided.
69	**Admitting Diagnosis**
	Enter the ICD-9-CM diagnosis code describing the admitting diagnosis.
76	**NPI**
	Enter the Attending Physician NPI number.

7.6 Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by the KY Medicaid Program, whether due to erroneous billing or payment system faults, shall be refunded to the KY Medicaid Program. Refund checks shall be made payable to "KY State Treasurer" and sent immediately to:

HP Enterprise ServicesP.O. Box 2108
Frankfort, KY 40602-2108
ATTN: Financial Services Unit

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse and prosecuted.

8 Medicare Deductibles and Coinsurance

Billing for Medicare Part A coinsurance days, Medicare Part B deductible or coinsurance and Title XIX services must be on separate billing forms. If the member was covered by Medicare Part A, Medicare Part B, and KY Medicaid, three UB-04 billing forms must be submitted for payment for the three types of benefits.

KY Medicaid PRO certification is not required on Medicare deductible and coinsurance claims. If all Medicare benefits are exhausted and Title XIX days are being billed, KY Medicaid PRO certification for those KY Medicaid days is necessary.

For nursing facility services, KY Medicaid pays Medicare coinsurance and deductibles up to the KY Medicaid maximum amount. At that point, KY Medicaid considers the provider as "paid in full". If the provider notes that Medicare has reimbursed more on a claim than the KY Medicaid maximum, it is not necessary to bill the KY Medicaid program. As always, the provider must not bill the KY Medicaid member for any differences between charges and payments.

8.1 Electronic Crossover of Medicare Claims

The following Medicare tape transferred claims WILL NOT BE PROCESSED by KY Medicaid:

- Claims for which there is no deductible or coinsurance amount due;
- * Medicare adjusted claims; and,
- ** Claims that indicate a third party payer source.

*If KY Medicaid has made payment for a deductible or coinsurance amount that has been Medicare adjusted, you should file an adjustment with KY Medicaid in the usual manner. If the Medicare adjustment indicates that a deductible or coinsurance amount is not due, a refund must be made to KY Medicaid in the usual manner. If KY Medicaid has not made payment on the claim that Medicare adjusts, you should submit a UB-04 billing form to KY Medicaid for the corrected amount.

**Claims that have third party payer involvement should be submitted to KY Medicaid on the UB-04 billing form in the usual manner.

The same edits and audits apply to Medicare tape transferred claims that are applied to paper claims. Listed below are some of the claims that **WILL AUTOMATICALLY BE DENIED** by KY Medicaid and must be appropriately resubmitted on a paper UB-04 billing form:

- Claims for dates of service prior to the effective date of your current KY Medicaid provider ID (these claims will deny under your current provider ID);
- Claims on which the "Statement Covers Period" is more than one calendar month (a KY Medicaid claim must be calendar month pure); and,
- Medicare Part A claims on which the "Statement Covers Period" is for dates of service inclusive of Medicare full-costs days and Medicare coinsurance days (the "Statement Covers Period" on a KY Medicaid claim, in relation to the type of bill, must equal Form Locator 7).

If a Medicare tape-transferred claim has not appeared on your KY Medicaid Remittance Advice within 30 days of the Medicare adjudication date, you should submit a claim to Kentucky Medicaid.

9 Appendix A

9.1 Revenue Codes Descriptions

9.1.1 Accommodations

110	Room & Board, private
120	Room & Board, semi private - two beds
130	Room & Board, semi private - three or four beds
140	Room & Board, private - deluxe
150	Room & Board, ward
160	Room & Board, Infectious Diseases
180	Bed Reserve Days, home or other
185	Bed Reserve Days, hospital

9.1.2 Laboratory

300	Laboratory, general
310	Laboratory-Pathological, general
311	Cytology
312	Histology
314	Biopsy

9.1.3 X-Ray

320	X-Ray

9.1.4 Oxygen

410	Oxygen

9.1.5 Physical Therapy

420	Physical Therapy
421 (PT 11 only)	Physical Therapy
422 (PT 11 only)	Physical Therapy

423 (PT 11 only)	Physical Therapy
424 (PT 11 only)	Physical Therapy

9.1.6 Occupational Therapy

430	Occupational Therapy
431 (PT 11 only)	Occupational Therapy
432 (PT 11 only)	Occupational Therapy
433(PT 11 only)	Occupational Therapy

9.1.7 Speech Therapy

440	Speech Therapy
441 (PT 11 only)	Speech Therapy
442 (PT 11 only)	Speech Therapy
443 (PT 11 only)	Speech Therapy
444 (PT 11 only)	Speech Therapy

9.1.8 Psychiatric/Psychological Services

910 (PT 11 only)	Psychiatric/Psychological Services, general
914 (PT 11 only)	Psychiatric/Psychological Services, individual therapy
915 (PT 11 only)	Psychiatric/Psychological Services, group therapy
918 (PT 11 only)	Psychiatric/Psychological Services, testing

10 Appendix B

10.1 Procedure Codes

10.1.1 Oxygen Therapy Procedure Codes

Oxygen Code	Procedure Description
E1390	Oxygen Concentrator
E0424	Stationary Compressed Gas O2
E0431	Portable Gaseous O2
E0434	Portable Liquid O2
E0450	Volume Ventilator – Stationary / Portable
Use Payment Modifiers	
QE	Prescribed amount less than 1 LPM or if oxygen is used 14 days or less within the month.
QG	Prescribed amount greater than 4 LPM.
QF	Prescribed amount is greater than 4 LPM and portable oxygen is prescribed.

Note: If a combination of stationary and portable oxygen has been prescribed by the physician and approved by KY Medicaid, a combination of two procedure codes may be utilized for billing. The second procedure code billed must be either E0431 or E0434.

The payment modifiers are available to use with the oxygen procedure codes for services that fall outside the normal parameters of oxygen use, as described above.

10.1.2 Speech Therapy Procedure Codes

Therapy Code	Procedure Description
92506	Speech Hearing Evaluation
92507	Speech Hearing Evaluation
92508	Speech Hearing Evaluation
92526	Oral Function Therapy
92610	Clinical Evaluation of Swallowing Function
96105	Assessment of Aphasia
97001	Speech Therapy Evaluation
97002	Speech Therapy Re-Evaluation
97110	Therapeutic Procedure One or More Areas Each 15 min.
97530	Therapeutic Activities, One on One, 15 min.

10.1.3 Lab Procedure Codes

Code	Procedure Description
36400	BL DRAW < 3 YRS FEM/JUGULAR
36405	BL DRAW < 3 YRS SCALP VEIN
36406	BL DRAW < 3 YRS OTHER VEIN
36410	NON-ROUTINE BL DRAW > 3 YRS
36415	ROUTINE VENIPUNCTURE
36416	CAPILLARY BLOOD DRAW
80048	BASIC METABOLIC PANEL
80050	GENERAL HEALTH PANEL
80053	COMPREHENSIVE METABOLIC PANEL
80061	LIPID PANEL
80069	RENAL FUNCTION PANEL
80074	ACUTE HEPATITIS PANEL
80076	HEPATIC FUNCTION PANEL
80100	DRUG SCREEN, QUALITATE/MULTI
80101	DRUG SCREEN, SINGLE
80102	DRUG CONFIRMATION
80103	DRUG ANALYSIS, TISSUE PREP
80150	ASSAY OF AMIKACIN
80152	ASSAY OF AMITRIPTYLINE
80154	ASSAY BENZODIAZEPINES
80156	ASSAY, CARBAMAZEPINE, TOTAL
80157	ASSAY, CARBAMAZEPINE, FREE
80158	ASSAY OF CYCLOSPORINE

Code	Procedure Description
80160	ASSAY OF DESIPRAMINE
80162	ASSAY OF DIGOXIN
80164	ASSAY, DIPROPYLACETIC ACID
80166	ASSAY OF DOXEPIN
80168	ASSAY OF ETHOSUXIMIDE
80170	ASSAY OF GENTAMICIN
80172	ASSAY OF GOLD
80173	ASSAY OF HALOPERIDOL
80174	ASSAY OF IMIPRAMINE
80176	ASSAY OF LIPOCAINE
80178	ASSAY OF LITHIUM
80182	ASSAY OF NORTRIPTYLINE
80184	ASSAY OF PHENOBARBITAL
80185	ASSAY OF PHENYTOIN, TOTAL
80186	ASSAY OF PHENYTOIN, FREE
80188	ASSAY OF PRIMIDONE
80190	ASSAY OF PROCAINAMIDE
80192	ASSAY OF PROCAINAMIDE
80194	ASSAY OF QUINIDINE
80196	ASSAY OF SALICYLATE
80197	ASSAY OF TACROLIMUS
80198	ASSAY OF THEOPHYLINE
80200	ASSAY OF TOBRAMYCIN
80202	ASSAY OF VANCOMYCIN

Code	Procedure Description
80299	QUANTITATIVE ASSAY, DRUG
81000	URINALYSIS, NONAUTO W/SCOPE
81001	URINALYSIS, AUTO W/SCOPE
81002	URINALYSIS, NONAUTO W/O SCOPE
81003	URINALYSIS, AUTO W/O SCOPE
81005	URINALYSIS
81007	URINE SCREEN FOR BACTERIA
81015	MICROSCOPIC EXAM OF URINE
81050	URINALYSIS, VOLUME MEASURE
81099	URINALYSIS TEST PROCEDURE
82009	TEST FOR ACETONE/KETONES
82270	TEST FOR BLOOD, FECES
82550	ASSAY OF CK (CPK)
82552	ASSAY OF CPK IN BLOOD
82575	CREATININE CLEARANCE TEST
82607	VITAMIN B-12
82803	BLOOD GASES: PH, PO2& PCO2
82805	BLOOD GASES W/02 SATURATION
82810	BLOOD GASES, 02 SAT ONLY
82948	REAGENT STRIP/BLOOD GLUCOSE
82950	GLUCOSE TEST
82951	GLUCOSE TOLERANCE TEST (GTT)
82962	GLUCOSE BLOOD TEST
83036	GLYCATED HEMOGLOBIN TEST

Code	Procedure Description
84152	ASSSAY OF PSA, COMPLEXED
84181	WESTERN BLOT TEST
84182	PROTEIN, WESTERN BLOT TEST
84442	ASSAY OF THYROID ACTIVITY
84443	ASSAY THYROID STIM HORMONE
84478	ASSAY OF TRIGLYCERIDES
84479	ASSAY OF THYROID (T3 OR T4)
84550	ASSAY OF BLOOD/URIC ACID
84999	CLINICAL CHEMISTRY TEST
85002	BLEEDING TIME TEST
85004	AUTOMATED DIFF WBC COUNT
85009	MANUAL DILL WBC COUNT B-COAT
85014	HEMATOCRIT
85018	HEMOGLOBIN
85025	COMPLETE CBC W/AUTO DIFF WBC
85175	BLOOD CLOT LYSIS TIME
85345	COAGULATION TIME
85520	HEPARIN ASSAY
85611	PROTHROMBIN TEST
85652	RBC SED RATE, AUTOMATED
86140	C-REACTIVE PROTEIN
86510	HISTOPLASMOSIS SKIN TEST
86580	TB INTRADERMAL TEST
86625	CAMPYLOBACTER ANTIBODY

Code	Procedure Description
86628	CANDIDA ANTIBODY
86674	GIARDIA LAMBLIA ANTIBODY
86677	HELICOBACTER PYLORI
86682	HELMINTH ANTIBODY
86701	HIV-1
86702	HIV-2
86703	HIV-1/HIV-2, SINGLE ASSAY
86704	HEP B CORE ANTIBODY, TOTAL
86707	HEP BE ANTIBODY
86708	HEP A ANTIBODY, TOTAL
86803	HEP C AB TEST
87040	BLOOD CULTURE FOR BACTERIA
87046	STOOL CULTR, BACTERIA, EACH
87070	CULTURE, BACTERIA, OTHER
87071	CULTURE BACTERIA AEROBIC OTHER
87073	CULTURE BACTERIA ANAEROBIC
87086	URINE CULTURE/COLONY COUNT
87088	URINE BACTERIA CULTURE
87177	OVA AND PARASITES SMEARS

10.1.4 Physical Therapy Codes

Code	Procedure Description
97001	PHYSICAL THERAPY EVALUATION
97002	PHYSICAL THERAPY RE-EVALUATION
97032	APPLICATION OF A MODALITY TO ONE OR MORE AREAS, ELECTRICAL STIMULATION, EACH 15 MIN.
97035	ULTRASOUND THERAPY, EACH 15 MIN.
97110	THERAPEUTIC PROCEDUREONE OR MORE AREAS, EACH 15 MIN.
97112	NEUROMUSCULAR REEDUCATION
97116	GAIT TRAINING, INCLUDING STAIR CLIMBING
97530	THERAPEUTIC ACTIVIES, DIRECT CONTACT EACH 15-MIN.
97535	SELF - CARE/HOME MANAGEMENT TRAINING
97542	WHEELCHAIR MANAGEMENT TRAINING

10.1.5 Occupational Therapy Codes

Code	Procedure Description
97003	OCCUPATIONAL THERAPY EVALUATION
97004	OCCUPATIONAL THERAPY RE-EVALUATION
97110	THERAPEUTIC PROCEDURE, ONE OR MORE AREAS, EACH 15 MIN.
97112	NEUROMUSCULAR REEDUCATION
97116	GAIT TRAINING, INCLUDING STAIR CLIMBING
97530	THERAPEUTIC ACTIVITIES, ONEON ONE, 15 MIN.
97532	COGNITIVE SKILLS DEVELOPMENT TO IMPROVE ATTENTION, MEMORY PROBLEM SOLVING, (INCLUDING COMPENSATORY TRIANING), DIRECT (ONE ON ONE) PATIENT CONTACT BY PROVIDER, EACH 15 MIN.
97535	SELF CARE MANAGEMENT TRAINING
97537	COMMUNITY/WORK REINTERGRATION
97542	WHEELCHAIR MANAGEMENT TRAINING

10.1.6 Radiology Codes

Code	Procedure Description
70370	THROAT X-RAY & FLUOROSCOPY
70371	SPEECH EVALUATION, COMPLEX
71010	CHEST X-RAY
71023	CHEST X-RAY AND FLUOROSCOPY
71100	X-RAY EXAM OF RIBS
71101	X-RAY EXAM OF RIBS/CHEST
71110	X-RAY EXAM OF RIBS
71111	X-RAY EXAM OF RIBS/CHEST
71120	X-RAY EXAM OF BREASTBONE
71130	X-RAY EXAM OF BREASTBONE
72010	X-RAY EXAM OF SPINE
72040	X-RAY EXAM OF NECK SPINE
72069	X-RAY EXAM OF TRUNK SPINE
72070	X-RAY EXAM OF THORACIC SPINE
72080	X-RAY EXAM OF TRUNK SPINE
72100	X-RAY EXAM OF LOWER SPINE
72170	X-RAY EXAM OF PELVIS
72190	X-RAY EXAM OF PELVIS
72200	X-RAY EXAM SACROILIAC JOINTS
72202	X-RAY EXAM SACROILIAC JOINTS
72220	X-RAY EXAM OF TAILBONE
72240	CONTRAST X-RAY OF NECK SPINE
72255	CONTRAST X-RAY, THORAX SPINE

Code	Procedure Description
72265	CONTRAST X-RAY, LOWER SPINE
72270	CONTRAST X-RAY OF SPINE
72285	X-RAY C/T SPINE DISK
72295	X-RAY OF LOWER SPINE DISK
73000	X-RAY EXAM OF COLLAR BONE
73010	X-RAY EXAM OF SHOULDER BLADE
73020	X-RAY EXAM OF SHOULDER
73030	X-RAY EXAM OF SHOULDER
73040	CONTRAST X-RAY OF SHOULDER
73050	X-RAY EXAM OF SHOULDERS
73060	X-RAY EXAM OF HUMERUS
73070	X-RAY EXAM OF ELBOW
73080	X-RAY EXAM OF ELBOW
73085	CONTRAST X-RAY OF ELBOW
73090	X-RAY EXAM OF FOREARM
73100	X-RAY OF WRIST 2 VIEWS
73110	X-RAY EXAM OF WRIST
73115	CONTRAST X-RAY OF WRIST
73120	X-RAY EXAM OF HAND
73130	X-RAY EXAM OF HAND
73140	X-RAY EXAM OF FINGER (S)
73500	X-RAY EXAM OF HIP
73510	X-RAY EXAM OF HIP
73520	X-RAY EXAM OF HIPS

Code	Procedure Description
73525	CONTRAST X-RAY OF HIP
73530	CONTRAST X-RAY OF HIP
73540	X-RAY EXAM OF PELVIS & HIPS
73542	X-RAY EXAM, SACROILIAC JOINT
73550	X-RAY EXAM OF THIGH
73560	X-RAY EXAM OF KNEE, 1 OR 2
73562	X-RAY EXAM OF KNEE, 3
73564	X-RAY EXAM, KNEE, 4 OR MORE
73565	X-RAY EXAM OF KNEES
73580	CONTRAST X-RAY OF KNEE JOINT
73590	X-RAY EXAM OF LOWER LEG
73600	X-RAY EXAM OF ANKLE
73610	X-RAY EXAM OF ANKLE
73615	CONTRAST X-RAY OF ANKLE
73620	X-RAY EXAM OF FOOT
73630	X-RAY FOOT 2 VIEWS
73650	X-RAY EXAM OF HEEL
73660	X-RAY EXAM OF TOE (S)
74000	X-RAY EXAM OF ABDOMEN
74010	X-RAY EXAM OF ABDOMEN
74020	X-RAY EXAM OF ABDOMEN
74022	X-RAY EXAM SERIES, ABDOMEN
74190	X-RAY EXAM OR PERITONEUM
74210	CONTRAST X-RAY EXAM OF THROAT

Code	Procedure Description
74220	CONTRAST X-RAY, ESOPHAGUS
74240	X-RAY EXAM, UPPER GI TRACT
74241	X-RAY EXAM, UPPER GI TRACT
74245	X-RAY EXAM, UPPER GI TRACT
74246	CONTRAST X-RAY UPPER GI TRACT
74247	CONTRAST X-RAY UPPER GI TRACT
74249	CONTRAST X-RAY UPPER GI TRACT
74250	X-RAY EXAM OF SMALL BOWEL
74251	X-RAY EXAM OF SMALL BOWEL
74260	X-RAY EXAM OF SMALL BOWEL
74270	CONTRAST X-RAY EXAM OF COLON
74280	CONTRAST X-RAY EXAM OF COLON
74283	CONTRAST X-RAY EXAM OF COLON
74290	CONTRAST X-RAY, GALLBLADDER
74291	CONTRAST X-RAYS, GALLBLADDER
74300	X-RAY BILE DUCTS/PANCREAS
74305	X-RAY BILE DUCTS/PANCREAS
74320	CONTRAST X-RAY OF BILE DUCTS
74327	X-RAY BILE STONE REMOVAL
74328	X-RAY BILE DUCT ENDOSCOPY
74329	X-RAY FOR PANCREAS ENDOSCOPY
74330	X-RAY BILE/PANC ENDOSCOPY
74340	X-RAY GUIDE FOR GI TUBE
74355	X-RAY GUIDE, INTESTINAL TUBE

Code	Procedure Description
74360	X-RAY GUIDE, GI DILATION
74363	X-RAY, BILE DUCT DILATION
74400	CONTRAST X-RAY, URINARY TRACT
74410	CONTRAST X-RAY, URINARY TRACT
74415	CONTRAST X-RAY, URINARY TRACT
74420	CONTRAST X-RAY, URINARY TRACT
74425	CONTRAST X-RAY, URINARY TRACT
74430	CONTRAST X-RAY, BLADDER
74440	X-RAY, MALE GENITAL TRACT
74445	X-RAY EXAM OF PENIS
74450	X-RAY, URETHRA/BLADDER
74455	X-RAY, URETHRA/BLADDER
74470	X-RAY EXAM OF KIDNEY LESION
74475	X-RAY CONTROL, CATH INSERT
74480	X-RAY CONTROL, CATH INSERT
74485	X-RAY GUIDE, GU DILATION
74740	X-RAY, FEMALE GENITAL TRACT
74742	X-RAY, FALLOPIAN TUBE
74775	X-RAY EXAM OF PERINEUM

11 Appendix C

11.1 Internal Control Number (ICN)

An Internal Control Number (ICN) is assigned by HP Enterprise Services to each claim. During the imaging process a unique control number is assigned to each individual claim for identification, efficient retrieval, and tracking. The ICN consists of 13 digits and contains the following information:

11 – 10 – 032 - 123456

1 2 3 4

1. Region

10	PAPER CLAIMS WITH NO ATTACHMENTS
11	PAPER CLAIMS WITH ATTACHMENTS
20	ELECTRONIC CLAIMS WITH NO ATTACHMENTS
21	ELECTRONIC CLAIMS WITH ATTACHMENTS
22	INTERNET CLAIMS WITH NO ATTACHMENTS
40	CLAIMS CONVERTED FROM OLD MMIS
45	ADJUSTMENTS CONVERTED FROM OLD MMIS
50	ADJUSTMENTS - NON-CHECK RELATED
51	ADJUSTMENTS - CHECK RELATED
52	MASS ADJUSTMENTS - NON-CHECK RELATED
53	MASS ADJUSTMENTS - CHECK RELATED
54	MASS ADJUSTMENTS - VOID TRANSACTION
55	MASS ADJUSTMENTS - PROVIDER RATES
56	ADJUSTMENTS - VOID NON-CHECK RELATED
57	ADJUSTMENTS - VOID CHECK RELATED

2. Year of Receipt
3. Julian Date of Receipt (The Julian calendar numbers the days of the year 1-365. For example, 001 is January 1 and 032 (shown above) is February 1.
4. Batch Sequence Used Internally

12 Appendix D

12.1 Remittance Advice

This section is a step-by-step guide to reading a Kentucky Medicaid Remittance Advice (RA). The following sections describe major categories related to processing/adjudicating claims. To enhance this document's usability, detailed descriptions of the fields on each page are included, reading the data from left to right, top to bottom.

12.1.1 Examples Of Pages In Remittance Advice

There are several types of pages in a Remittance Advice, including separate page types for each type of claim; however, if a provider does not have activity in that particular category, those pages are not included.

Following are examples of pages which may appear in a Remittance Advice:

FIELD	DESCRIPTION
Returned Claims	This section lists all claims that have been returned to the provider with an RTP letter. The RTP letter explains why the claim is being returned. These claims are returned because they are missing information required for processing.
Paid Claims	This section lists all claims paid in the cycle.
Denied Claims	This section lists all claims that denied in the cycle.
Claims In Process	This section lists all claims that have been suspended as of the current cycle. The provider should maintain this page and compare with future Remittance Advices until all the claims listed have appeared on the PAID CLAIMS page or the DENIED CLAIMS page. Until that time, the provider need not resubmit the claims listed in this section.
Adjusted Claims	This section lists all claims that have been submitted and processed for adjustment or claim credit transactions.
Mass Adjusted Claims	This section lists all claims that have been mass adjusted at the request of the Department for Medicaid Services (DMS).
Financial Transactions	This section lists financial transactions with activity during the week of the payment cycle.
	NOTE: It is imperative the provider maintains any A/R page with an outstanding balance.

Summary	This section details all categories contained in the Remittance Advice for the current cycle, month to date, and year to date. Explanation of Benefit (EOB) codes listed throughout the Remittance Advice is defined in this section.
EOB Code Descriptions	Any Explanation of Benefit Codes (EOB) which appear in the RA are defined in this section.

NOTE: For the purposes of reconciliation of claims payments and claims resubmission of denied claims, it is highly recommended that all remittance advices be kept for at least one year.

12.2 Title

The header information that follows is contained on every page of the Remittance Advice.

```
REPORT:   CRA-XBPD-R              COMMONWEALTH OF KENTUCKY (M1)              DATE:  01/25/2007
  RA#:     9999999          MEDICAID MANAGEMENT INFORMATION SYSTEM           PAGE:          2
                                  PROVIDER REMITTANCE ADVICE
```

FIELD	DESCRIPTION
DATE	The date the Remittance Advice was printed.
RA NUMBER	A system generated number for the Remittance Advice.
PAGE	The number of the page within each Remittance Advice.
CLAIM TYPE	The type of claims listed on the Remittance Advice.
PROVIDER NAME	The name of the provider that billed. (The type of provider is listed directly below the name of provider.)
PAYEE ID	The eight-digit Medicaid assigned provider ID of the billing provider.
NPI ID	The NPI number of the billing provider.

The category (type of page) begins each section and is centered (for example, *PAID CLAIMS*). All claims contained in each Remittance Advice are listed in numerical order of the prescription number.

12.3 Banner Page

All Remittance Advices have a “banner page” as the first page. The “banner page” contains provider specific information regarding upcoming meetings and workshops, “top ten” billing errors, policy updates, billing changes etc. Please pay close attention to this page.

REPORT: CRA-BANN-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
PROVIDER BANNER MESSAGES

DATE: 01/23/2007
PAGE: 1

PROVIDER
555 ANY STREET
CITY, KY 55555-0000

PAYEE ID	99999999
NPI ID	99999999
CHECK/EFT NUMBER	999999999
ISSUE DATE	01/26/2007

Commonwealth of Kentucky

REPORT: CRA-IPPD-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
UB CLAIMS PAID

DATE: 01/30/2007
PAGE: 2

PROVIDER
5555 ANY STREET
CITY, KY 55555-5555

PAYEE ID 99999999
NPI ID
CHECK/EFT NUMBER 999999999
ISSUE DATE 02/02/2007

--ICN-- / PAT.ACCT NUM.	ATTENDING PROV.	SERVICE DATES FROM	THRU	DAYS	ADMIT DATE	BILLED AMT	ALLOWED AMT	SPENDDOWN COPAY AMT	TPL AMT	PAID AMT
MEMBER NAME: JANE DOE		MEMBER NO.: MBRID99999								
ICN9999999999	NPI9999999	030806	031006	2	030806	6,307.35	0.00	0.00	0.00	3,488.25
PATACCT 99999999999								0.00		

HEADER EOBS: 9932 00A2

REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	ALLOWED AMT	DETAIL EOBS
120		030806	DEF	2.00	1,700.00	0.00	2527 0062 0883 0018
250		030806	DEF	48.00	653.90	0.00	9932 0018
258		030806	DEF	7.00	275.30	0.00	9932 0018
270		030806	DEF	67.00	386.15	0.00	9932 0018
300		030806	DEF	12.00	292.00	0.00	9932 0018
310		030806	DEF	3.00	177.00	0.00	9932 0018
360		030806	DEF	1.00	2,148.00	0.00	9932 0018
370		030806	DEF	1.00	299.00	0.00	9932 0018
710		030806	DEF	1.00	376.00	0.00	9932 0018

--ICN-- / PAT.ACCT NUM.	ATTENDING PROV.	SERVICE DATES FROM	THRU	DAYS	ADMIT DATE	BILLED AMT	ALLOWED AMT	SPENDDOWN COPAY AMT	TPL AMT	PAID AMT
MEMBER NAME: JANE DOE		MEMBER NO.: 9999999999								
9999999999999	9999999999	030806	031006	2	030806	6,307.35	0.00	0.00	0.00	3,488.25
99999999999								0.00		

HEADER EOBS: 9932 0018

REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	ALLOWED AMT	DETAIL EOBS
120		030806	DEF	2.00	1,700.00	0.00	9932 0018 0275 0015
250		030806	DEF	48.00	653.90	0.00	9932 0015 0883 00
258		030806	DEF	7.00	275.30	0.00	9932 0018
270		030806	DEF	67.00	386.15	0.00	9932 0018
300		030806	DEF	12.00	292.00	0.00	9932 0018
310		030806	DEF	3.00	177.00	0.00	9932 0018
360		030806	DEF	1.00	2,148.00	0.00	9932 0018
370		030806	DEF	1.00	299.00	0.00	9932 0018
710		030806	DEF	1.00	376.00	0.00	9932 0018

TOTAL UB CLAIMS PAID:	12,614.70	0.00	0.00	0.00	6,976.50

12.4 Paid Claims Page

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Account Number from Form Locator 3.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
ATTENDING PROVIDER	The member's attending provider.
CLAIM SERVICE DATES FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
DAYS	The number of days billed.
ADMIT DATE	The admit date of the member.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
ALLOWED AMOUNT	The allowed amount for Medicaid
SPENDDOWN COPAY AMOUNT	The amount collected from the member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
PAID AMOUNT	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
CLAIMS PAID ON THIS RA	The total number of paid claims on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed by the provider for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).
TOTAL PAID	The total dollar amount paid by Medicaid for all claims listed on the PAID CLAIMS page of the Remittance Advice (only on final page of section).

REPORT: CRA-IPDN-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
UB CLAIMS DENIED

DATE: 01/25/2007
PAGE: 11

PROVIDER
5555 ANY STREET
SUITE 555
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID 99999999
CHECK/EFT NUMBER 999999999
ISSUE DATE 01/26/2007

--ICN-- PATIENT ACCT.	ATTENDING PROV. NUM.	SERVICE DATES FROM	THRU	DAYS	ADMIT DATE	BILLED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT
MEMBER NAME: JANE DOE		MEMBER NO.: MBRID99999						
ICN9999999999 PATACCT9999	NPI9999999	021706	022106	4	021706	10,212.66	0.00	0.00

HEADER EOBS: 2660 0092

REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	DETAIL EOBS
174		021706	DEF	4.00	9,382.04	2527 0062
250		021706	DEF	3.00	15.96	9953 0062 0883 001
300		021706	DEF	5.00	355.28	9953 0018
301		021706	DEF	11.00	361.54	9953 0018
302		021706	DEF	3.00	81.42	9953 0018
306		021706	DEF	1.00	16.42	9953 0018

MEMBER NAME: JANE DOE		MEMBER NO.: 9999999999						
9999999999999 99999999	MCD 9999	021706	022106	4	021706	10,802.46	0.00	0.00

HEADER EOBS: 2198 0016

REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	DETAIL EOBS
111		021706	DEF	3.00	1,805.40	
112		021706	DEF	1.00	601.80	
250		021706	DEF	232.00	608.33	
258		021706	DEF	27.00	122.17	
272		021706	DEF	1.00	206.78	
300		021706	DEF	6.00	374.96	
301		021706	DEF	29.00	909.72	
307		021706	DEF	2.00	50.45	
312		021706	DEF	3.00	582.99	
370		021706	DEF	1.00	663.54	
460		021706	DEF	1.00	15.06	
720		021706	DEF	3.00	4,549.14	
732		021706	DEF	1.00	312.12	

TOTAL UB CLAIMS DENIED:	21,015.12	200.00	0.00

12.5 Denied Claims Page

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
ATTENDING PROVIDER	The member's attending provider.
CLAIM SERVICE DATE FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
DAYS	The number of days billed.
ADMIT DATE	The admit date of the member.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount owed from the member.
CLAIM PMT. AMT.	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
CLAIMS DENIED ON THIS RA	The total number of denied claims on the Remittance Advice.
TOTAL BILLED	The total dollar amount billed by the Home Health Services for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on final page of section).
TOTAL PAID	The total dollar amount paid by Medicaid for all claims listed on the DENIED CLAIMS page of the Remittance Advice (only on final page of section).

REPORT: CRA-IPSU-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
UB CLAIMS IN PROCESS

DATE: 01/25/2007
PAGE: 17

PROVIDER
5555 ANY STREET
SUITE 555
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID 99999999
CHECK/EFT NUMBER 999999999
ISSUE DATE 01/26/2007

--ICN-- PATIENT ACCT. NUM.	ATTENDING PROV.	SERVICE DATES FROM	SERVICE DATES THRU	DAYS	ADMIT DATE	BILLED AMOUNT	TPL AMOUNT	SPENDDOWN AMOUNT
MEMBER NAME: JOHN DOE			MEMBER NO.: MBRID99999					
ICN9999999999 NPI9999999		062206	062406	2	062206	4,010.60	0.00	0.00
PATACCT9999								

REV CD	HCPCS/RATE	SRV DATE	LVL CARE	UNITS	BILLED AMT	DETAIL EOBS
111		062206	DEF	2.00	1,203.60	
250		062206	DEF	42.00	587.84	
258		062206	DEF	22.00	455.82	
272		062206	DEF	1.00	9.01	
370		062206	DEF	1.00	774.12	
410		062206	DEF	6.00	387.76	
710		062206	DEF	1.00	592.45	

TOTAL UB CLAIMS IN PROCESS:	4010.60	0.00	0.00

12.6 Claims In Process Page

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 13-digit unique system-generated identification number assigned to each claim by HP Enterprise Services.
ATTENDING PROVIDER	The attending provider's NPI.
CLAIM SERVICE DATE FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
DAYS	The number of days billed.
ADMIT DATE	The admit date of member.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
SPENDDOWN AMOUNT	The amount owed from the member.

REPORT: CRA-IPPD-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
UB CLAIMS RETURNED

DATE: 01/30/2007
PAGE: 2

PROVIDER
5555 ANY STREET
CITY, KY 55555-5555

PAYEE ID 99999999
NPI ID
CHECK/EFT NUMBER 999999999
ISSUE DATE 02/02/2007

--ICN--	REASON CODE
9999999999999	01

CLAIMS RETURNED: 01

12.7 Returned Claim

FIELD	DESCRIPTION
ICN	The 13-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
REASON CODE	A code denoting the reason for returning the claim.
CLAIMS RETURNED ON THIS RA	The total number of returned claims on the Remittance Advice.

Note: Claims appearing on the "returned claim" page are forthcoming in the mail. The actual claim is returned with a "return to provider" sheet attached, indicating the reason for the claim being returned.

REPORT: CRA-HHAD-R — COMMONWEALTH OF KENTUCKY (M1) — DATE: 01/23/2007
RA#: 9999999 — MEDICAID MANAGEMENT INFORMATION SYSTEM — PAGE: 33
PROVIDER REMITTANCE ADVICE
UB CLAIM ADJUSTMENTS

PROVIDER
55555 ANY STREET
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID

--ICN-- / --PATIENT NUMBER--	ATTEND PROV.	SERVICE DATES FROM	SERVICE DATES THRU	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	SPENDDOWN AMOUNT	PAID AMOUNT
MEMBER NAME: JOHN DOE		MEMBER NO.: 9999999999							
9999999999999 / 99999999999999	MCD 9999	030106	033106	(3,886.47)	(0.00)	(0.00)	(0.00)	(0.00)	(3,592.90)
9999999999999 / 99999999999999	MCD 9999	030106	033106	3,886.47	0.00	0.00	0.00	0.00	0.00

HEADER EOBS: 0053 00A1

REV CD	HCPCS/RATE	SRV DATE	MODIFIERS	UNITS	BILLED AMT	ALLOWED AMT	DETAIL EOBS	
651		030106		31.00	3,886.47	0.00	0686 0119	
						NET OVERPAYMENT (AR)		3,592.90

TOTAL NO. OF ADJ: 1

TOTAL UB ADJUSTMENT CLAIMS:	0.00	0.00	0.00	
		0.00	0.00	-3,592.90

Providers have an option of requesting an adjustment, as indicated above; or requesting a cash refund (form and instructions for completion can be found in the Billing Instructions).
If a cash refund is submitted, an adjustment **CANNOT** be filed.
If an adjustment is submitted, a cash refund **CANNOT** be filed.

12.8 Adjusted Claims Page

The information on this page reads left to right and does not follow the general headings.

FIELD	DESCRIPTION
PATIENT ACCOUNT	The 14-digit alpha/numeric Patient Control Number from Form Locator 3.
MEMBER NAME	The Member's last name and first initial.
MEMBER NUMBER	The Member's ten-digit Identification number as it appears on the Member's Identification card.
ICN	The 12-digit unique system generated identification number assigned to each claim by HP Enterprise Services.
CLAIM SERVICE DATES FROM – THRU	The date or dates the service was provided in month, day, and year numeric format.
BILLED AMOUNT	The usual and customary charge for services provided for the Member.
ALLOWED AMOUNT	The amount allowed for this service.
TPL AMOUNT	Amount paid, if any, by private insurance (excluding Medicaid and Medicare).
COPAY AMOUNT	Copay amount to be collected from member.
SPENDDOWN AMOUNT	The amount to be collected from the member.
PAID AMOUNT	The total dollar amount reimbursed by Medicaid for the claim listed.
EOB	Explanation of Benefits. All EOBs detailed on the Remittance Advice are listed with a description/definition at the end of the Remittance Advice.
PAID AMOUNT	Amount paid.

Note: The ORIGINAL claim information appears first, followed by the NEW (adjusted) claim information.

REPORT: CRA-TRAN-R COMMONWEALTH OF KENTUCKY DATE: 12/26/2006
RA#: 9999999 MEDICAID MANAGEMENT INFORMATION SYSTEM PAGE: 2
PROVIDER REMITTANCE ADVICE
FINANCIAL TRANSACTIONS

PROVIDER J PAYEE ID 99999999
PO BOX 5555 NPI ID 99999999
CITY, KY 55555-5555

----------NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS----------

TRANSACTION NUMBER	--CCN--	--AMOUNT--	REASON CODE	RENDERING PROVIDER	SVC DATE FROM	SVC DATE THRU	MEMBER NO.	MEMBER NAME

NO NON-CLAIM SPECIFIC PAYOUTS TO PROVIDERS

----------NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS----------

--CCN--	--AMOUNT--	REASON CODE	MEMBER NO.	MEMBER NAME

NO NON-CLAIM SPECIFIC REFUNDS FROM PROVIDERS

----------ACCOUNTS RECEIVABLE----------

A/R NUMBER/ICN	SETUP DATE	RECOUPED THIS CYCLE	ORIGINAL AMOUNT	TOTAL -RECOUPED-	--BALANCE--	REASON CODE	
1106	011306	0.00	22.41	0.00	22.41	92	
TOTAL BALANCE					22.41		

12.9 Financial Transaction Page

12.9.1 Non-Claim Specific Payouts To Providers

FIELD	DESCRIPTION
TRANSACTION NUMBER	The tracking number assigned to each financial transaction.
CCN	The cash control number assigned to refund checks for tracking purposes.
PAYMENT AMOUNT	The amount paid to the provider when the financial reason code indicates money is owed to the provider.
REASON CODE	Payment reason code.
RENDERING PROVIDER	Rendering provider of service.
SERVICE DATES	The From and Through dates of service.
MEMBER NUMBER	The KY Medicaid member identification number.
MEMBER NAME	The KY Medicaid member name.

12.9.2 Non-Claim Specific Refunds From Providers

FIELD	DESCRIPTION
CCN	The cash control tracking number assigned to refund checks for tracking purposes.
REFUND AMOUNT	The amount refunded by provider.
REASON CODE	The two byte reason code specifying the reason for the refund.
MEMBER NUMBER	The KY Medicaid member identification number.
MEMBER NAME	The KY Medicaid member name.

12.9.3 Accounts Receivable

FIELD	DESCRIPTION
A / R NUBMER / ICN	This is the 13-digit Internal Control Number used to identify records for one accounts receivable transaction.
SETUP DATE	The date entered on the accounts receivable transaction in the MM/DD/CCYY format. This date identifies the beginning of the accounts receivable event.

RECOUPED THIS CYCLE	The amount of money recouped on this financial cycle.
ORIGINAL AMOUNT	The original accounts receivable transaction amount owed by the provider.
TOTAL RECOUPED	This amount is the total of the providers checks and recoupment amounts posted to this accounts receivable transaction.
BALANCE	The system generated balance remaining on the accounts receivable transaction.
REASON CODE	A two-byte alpha/numeric code specifying the reason an accounts receivable was processed against a providers account.

ANY RECOUPMENT ACTIVITY OR PAYMENTS RECEIVED FROM THE PROVIDER list below the “RECOUPMENT PAYMENT SCHEDULE.” All initial accounts receivable allow 60 days from the “setup date” to make payment on the accounts receivable. After 60 days, if the accounts receivable has not been satisfied nor a payment plan initiated, monies are recouped from the provider on each Remittance Advice until satisfied.

This is your only notification of an accounts receivable setup. Please keep all Accounts Receivable Summary pages until all monies have been satisfied.

REPORT: CRA-SUMM-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
SUMMARY

DATE: 02/01/2007
PAGE: 13

PROVIDER

P O BOX 555
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID
CHECK/EFT NUMBER 999999999
ISSUE DATE 02/02/2007

----------CLAIMS DATA----------

	CURRENT NUMBER	CURRENT AMOUNT	MONTH-TD NUMBER	MONTH-TD AMOUNT	YEAR-TD NUMBER	YEAR-TD AMOUNT
CLAIMS PAID	43	130,784.46	43	130,784.46	1,988	4,143,010.13
CLAIM ADJUSTMENTS	0	0.00	0	0.00	18	0.00
MASS ADJUSTMENTS	0	0.00	0	0.00	0	0.00
TOTAL CLAIMS PAYMENTS	43	130,784.46	43	130,784.46	2,006	4,143,010.13
CLAIMS DENIED	1		1		917	
CLAIMS IN PROCESS	2					

----------EARNINGS DATA----------

PAYMENTS:			
CLAIMS PAYMENTS	130,784.46	130,784.46	4,143,010.13
SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)	0.00	0.00	0.00
ACCOUNTS RECEIVABLE (OFFSETS):			
CLAIM SPECIFIC:			
CURRENT CYCLE	(0.00)	(0.00)	(0.00)
OUTSTANDING FROM PREVIOUS CYCLES	(0.00)	(0.00)	(44,474.35)
NON-CLAIM SPECIFIC OFFSETS	(0.00)	(0.00)	(0.00)
NET PAYMENT	130,784.46	130,784.46	4,098,535.78
REFUNDS:			
CLAIM SPECIFIC ADJUSTMENT REFUNDS	(0.00)	(0.00)	(0.00)
NON-CLAIM SPECIFIC REFUNDS	(0.00)	(0.00)	(0.00)
OTHER FINANCIAL:			
MANUAL PAYOUTS (NON-CLAIM SPECIFIC)	0.00	0.00	0.00
VOIDS	(0.00)	(0.00)	(0.00)
NET EARNINGS	130,784.46	130,784.46	4,098,535.78

REPORT: CRA-EOBM-R
RA#: 9999999

COMMONWEALTH OF KENTUCKY (M1)
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
EOB CODE DESCRIPTIONS

DATE: 02/01/2007
PAGE: 14

PROVIDER

P O BOX 555
CITY, KY 55555-0000

PAYEE ID 99999999
NPI ID
CHECK/EFT NUMBER 999999999
ISSUE DATE 02/02/2007

EOB CODE	EOB CODE DESCRIPTION
0022	COVERED DAYS ARE NOT EQUAL TO ACCOMMODATION UNITS.
0271	CLAIM DENIED. MEMBER AVAILABLE INCOME INFORMATION NOT ON FILE FOR THE MONTH OF SERVICE. PLEASE CONTACT DMS AT 502-564-6885.
0409	INVALID PROVIDER TYPE BILLED ON CLAIM FORM.
0883	CLAIM DENIED. DEPLICATE PROCEDURE HAS BEEN PAID.
9999	PROCESSED PER MEDICAID POLICY

HIPAA REASON CODE	HIPAA ADJ REASON CODE DESCRIPTION
0016	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
0018	Duplicate claim/service.
0052	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
0092	Claim Paid in full.
00A1	Claim denied charges.

12.10 Summary Page

FIELD	DESCRIPTION
CLAIMS PAID	The number of paid claims processed, current month and year to date.
CLAIM ADJUSTMENTS	The number of adjusted/credited claims processed, adjusted/credited amount billed, and adjusted/credited amount paid or recouped by Medicaid. If money is recouped, the dollar amount is followed by a negative (-) sign. These figures correspond with the summary of the last page of the ADJUSTED CLAIMS section.
PAID MASS ADJ CLAIMS	The number of mass adjusted/credited claims, mass adjusted/credited amount billed, and mass adjusted/credited amount paid or recouped by Medicaid. These figures correspond with the summary line of the last page of the MASS ADJUSTED CLAIMS section. Mass Adjustments are initiated by Medicaid and HP Enterprise Services for issues that affect a large number of claims or providers. These adjustments have their own section “MASS ADJUSTED CLAIMS” page, but are formatted the same as the ADJUSTED CLAIMS page.
CLAIMS DENIED	These figures correspond with the summary line of the last page of the DENIED CLAIMS section.
CLAIMS IN PROCESS	The number of claims processed that suspended along with the amount billed of the suspended claims. These figures correspond with the summary line of the last page of the CLAIMS IN PROCESS section.

12.10.1 Payments

FIELD	DESCRIPTION
CLAIMS PAYMENT	The number of claims paid.
SYSTEM PAYOUTS	Any money owed to providers.
NET PAYMENT	Net payment amount.
REFUNDS	Any money refunded to Medicaid by a provider.

OTHER FINANCIAL	
NET EARNINGS	Total check amount.

EXPLANATION OF BENEFITS

FIELD	DESCRIPTION
EOB	A five-digit number denoting the EXPLANATION OF BENEFITS detailed on the Remittance Advice.
EOB CODE DESCRIPTION	Description of the EOB Code. All EOB Codes detailed on the Remittance Advice are listed with a description/ definition.
COUNT	Total number of times an EOB Code is detailed on the Remittance Advice.

EXPLANATION OF REMARKS

FIELD	DESCRIPTION
REMARK	A five-digit number denoting the remark identified on the Remittance Advice.
REMARK CODE DESCRIPTION	Description of the Remark Code. All remark codes detailed on the Remittance Advice are listed with a description/definition.
COUNT	Total number of times a Remark Code is detailed on the Remittance Advice.

EXPLANATION OF ADJUSTMENT CODE

FIELD	DESCRIPTION
ADJUSTMENT CODE	A two-digit number denoting the reason for returning the claim.
ADJUSTMENT CODE DESCRIPTION	Description of the adjustment Code. All adjustment codes detailed on the Remittance Advice are listed with a description/definition.
COUNT	Total number of times an adjustment Code is detailed on the Remittance Advice.

EXPLANATION OF RTP CODES

FIELD	DESCRIPTION
RTP CODE	A two-digit number denoting the reason for returning the claim.
RETURN CODE DESCRIPTION	Description of the RTP Code. All RTP codes detailed on the Remittance Advice are listed with a description/ definition.
COUNT	Total number of times an RTP Code is detailed on the Remittance Advice.

13 Appendix E

13.1 Remittance Advice Location Codes (LOC CD)

The following is a code indicating the Department for Medicaid Services branch/division or other agency that originated the Accounts Receivable:

A Active

B Hold Recoup - Payment Plan Under Consideration

C Hold Recoup - Other

D Other-Inactive-FFP-Not Reclaimed

E Other – Inactive - FFP

F Paid in Full

H Payout on Hold

I Involves Interest – Cannot Be Recouped

J Hold Recoup Refund

K Inactive-Charge off – FFP Not Reclaimed

P Payout – Complete

Q Payout – Set Up In Error

S Active - Prov End Dated

T Active Provider A/R Transfer

U HP Enterprise Services On Hold

W Hold Recoup - Further Review

X Hold Recoup - Bankruptcy

Y Hold Recoup - Appeal

Z Hold Recoup - Resolution Hearing

14 Appendix F

14.1 Remittance Advice Reason Code (ADJ RSN CD or RSN CD)

The following is a two-byte alpha/numeric code specifying the reason an accounts receivable was processed against a provider's account:

01	Prov Refund – Health Insur Paid
02	Prov Refund – Member/Rel Paid
03	Prov Refund – Casualty Insu Paid
04	Prov Refund – Paid Wrong Vender
05	Prov Refund – Apply to Acct Recv
06	Prov Refund – Processing Error
07	Prov Refund-Billing Error
08	Prov Refund – Fraud
09	Prov Refund – Abuse
10	Prov Refund – Duplicate Payment
11	Prov Refund – Cost Settlement
12	Prov Refund – Other/Unknown
13	Acct Receivable – Fraud
14	Acct Receivable – Abuse
15	Acct Receivable – TPL
16	Acct Recv – Cost Settlement
17	Acct Receivable – HP Enterprise Services Request
18	Recoupment – Warrant Refund
19	Act Receivable-SURS Other
20	Acct Receivable – Dup Payt
21	Recoupment – Fraud
22	Civil Money Penalty
23	Recoupment – Health Insur TPL
24	Recoupment – Casualty Insur TPL
25	Recoupment – Member Paid TPL
26	Recoupment – Processing Error
27	Recoupment – Billing Error
28	Recoupment – Cost Settlement
29	Recoupment – Duplicate Payment
30	Recoupment – Paid Wrong Vendor
31	Recoupment – SURS
32	Payout – Advance to be Recouped
33	Payout – Error on Refund
34	Payout – RTP
35	Payout – Cost Settlement
36	Payout – Other
37	Payout – Medicare Paid TPL
38	Recoupment – Medicare Paid TPL
39	Recoupment – DEDCO
40	Provider Refund – Other TLP Rsn
41	Acct Recv – Patient Assessment
42	Acct Recv – Orthodontic Fee
43	Acct Receivable – KENPAC
44	Acct Recv – Other DMS Branch
45	Acct Receivable – Other
46	Acct Receivable – CDR-HOSP-Audit
47	Act Rec – Demand Paymt Updt 1099
48	Act Rec – Demand Paymt No 1099
49	PCG
50	Recoupment – Cold Check
51	Recoupment – Program Integrity Post Payment Review Contractor A
52	Recoupment – Program Integrity Post Payment Review Contractor B
53	Claim Credit Balance
54	Recoupment – Other St Branch
55	Recoupment – Other
56	Recoupment – TPL Contractor
57	Acct Recv – Advance Payment
58	Recoupment – Advance Payment
59	Non Claim Related Overage
60	Provider Initiated Adjustment
61	Provider Initiated CLM Credit

62	CLM CR-Paid Medicaid VS Xover
63	CLM CR-Paid Xover VS Medicaid
64	CLM CR-Paid Inpatient VS Outp
65	CLM CR-Paid Outpatient VS Inp
66	CLS Credit-Prov Number Changed
67	TPL CLM Not Found on History
68	FIN CLM Not Found on History
69	Payout-Withhold Release
71	Withhold-Encounter Data Unacceptable
72	Overage .99 or Less
73	No Medicaid/Partnership Enrollment
74	Withhold-Provider Data Unacceptable
75	Withhold-PCP Data Unacceptable
76	Withhold-Other
77	A/R Member IPV
78	CAP Adjustment-Other
79	Member Not Eligible for DOS
80	Adhoc Adjustment Request
81	Adj Due to System Corrections
82	Converted Adjustment
83	Mass Adj Warr Refund
84	DMS Mass Adj Request
85	Mass Adj SURS Request
86	Third Party Paid – TPL
87	Claim Adjustment – TPL
88	Beginning Dummy Recoupment Bal
89	Ending Dummy Recoupment Bal
90	Retro Rate Mass Adj
91	Beginning Credit Balance
92	Ending Credit Balance
93	Beginning Dummy Credit Balance
94	Ending Dummy Credit Balance
95	Beginning Recoupment Balance
96	Ending Recoupment Balance
97	Begin Dummy Rec Bal
98	End Dummy Recoup Balance
99	Drug Unit Dose Adjustment
AA	PCG 2 Part A Recoveries
BB	PCG 2 Part B Recoveries
CB	PCG 2 AR CDR Hosp
DG	DRG Retro Review
DR	Deceased Member Recoupment
IP	Impact Plus
IR	Interest Payment
CC	Converted Claim Credit Balance
MS	Prog Intre Post Pay Rev Cont C
OR	On Demand Recoupment Refund
RP	Recoupment Payout
RR	Recoupment Refund
SS	State Share Only
UA	HP Enterprise Services Medicare Part A Recoup
XO	Reg. Psych. Crossover Refund

15 Appendix G

15.1 Remittance Advice Status Code (ST CD)

The following is a one-character code indicating the status of the accounts receivable transaction:

A Active

B Hold Recoup - Payment Plan Under Consideration

C Hold Recoup - Other

D Other-Inactive-FFP-Not Reclaimed

E Other – Inactive - FFP

F Paid in Full

H Payout on Hold

I Involves Interest – Cannot Be Recouped

J Hold Recoup Refund

K Inactive-Charge off – FFP Not Reclaimed

P Payout – Complete

Q Payout – Set Up In Error

S Active - Prov End Dated

T Active Provider A/R Transfer

U HP Enterprise Services On Hold

W Hold Recoup - Further Review

X Hold Recoup - Bankruptcy

Y Hold Recoup - Appeal

Z Hold Recoup - Resolution Hearing